Maternal and Child Health Services
Title V Block Grant

State Narrative for Mississippi

Application for 2010
Annual Report for 2008

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I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section.

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

The MSDH has a copy of the Assurances and Certifications on file. If you wish to review this file, please contact John Justice by email at john.justice@msdh.state.ms.us or phone at (601) 576-7688.

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published March 2009; expires March 31, 2012.

E. Public Input

/2009/ The Mississippi State Department of Health (MSDH) solicits public input when hosting or presenting at workshops or conferences, and from the agency's webpage to maximize the opportunity for residents and community leaders to make comments and discuss their concerns. Copies of the MCH Block Grant and the Executive Summary are made available to community health centers and each of the nine public health district offices to allow residents the opportunity to visit and view these documents at their convenience. Phone calls and emails are also initiated to encourage district and local health department staff and community health centers to invite key community leaders to share their opinions and/or comments regarding the implementation of MCH Block Grant services in their communities.

The MCH central office staff uses every opportunity to inform other partners and providers of the goals, objectives and activities of the MCH Block Grant at meetings, health fairs, and conferences. When the MSDH conducts its next five-year needs assessment, scheduled to begin in the fall of 2009, public input will be solicited in the form of consumer surveys, focus groups and needs assessment conferences and/or meetings from professionals and consumers alike.

Public input also continues to be solicited through key parent and family support groups who are affiliated with programs funded by the grant.

II. Needs Assessment

In application year 2010, it is recommended that only Section IIC be provided outlining updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

In application year 2009, it is recommended that only Section IIC be provided outlining any updates that may have occurred.

/2010/ Based on the MCH priorities set by the State Needs Assessment, the Office of Health Data and Research (OHDR) along with the Offices of Women's Health, Child and Adolescent Health, WIC, Tobacco Control, Preventive Health, and Oral Health conduct multiple assessment and research activities throughout every year. The nine Mississippi Public Health Districts were visited for a comprehensive program review between January 2008 and April 2009. Participation in the MCH Block Grant preparation is sought at least annually at the district and local levels to receive input on resources, activities, and community needs.

Needs assessment is an ongoing activity for the MSDH. Multiple reports are generated subsequent to surveillance activities and data analysis which serve as part of an ongoing needs assessment review. The OHDR produces an annual analysis and report on Mississippi infant mortality and birth outcomes which is submitted annually to the Mississippi State Legislature. The OHDR reviews at least monthly MSDH Patient Information Management System (PIMS) data on PHRM and EPSDT to assess service delivery and client needs. PRAMS data collection is ongoing and provides vital needs assessment data relevant to the pregnancy experience among Mississippi women. Other study topics include childhood obesity, infant/child death reviews, childhood asthma, and oral health. Many study findings and surveillance reports are available to the public through the agency website.

The immigrant population in Mississippi is growing which requires an assessment of needs of both the Mississippi State Department of Health (MSDH) and the immigrant population relative to the unique challenges in assuring health care for this group. To that end, a needs assessment survey was administered by the MSDH Office of Health Disparity Elimination (OHDE) to those who provide services to populations unable to communicate effectively in English. Results are being compiled and analyzed and will inform the upcoming 2010 Needs Assessment (NA).

Activities are already underway for the initiation of the 2010 NA for the MCH Block Grant. A NA director has been appointed by the Title V Director and appropriate staff have attended the MCHB and AMCHP NA trainings in Atlanta and Washington DC. The director will be the Health Services Chief Nurse who brings considerable experience with the previous 2005 NA and other needs assessment activities to the team. A calendar has been established setting due dates for key activities throughout the completion of the task. An application was submitted and approved for the Agency to have a MCHB-sponsored graduate student intern assigned to assist with the early NA activities during the summer of 2009. We anticipate full implementation of the 2010 NA plan as early as August 2009 with final completion by mid-May 2010. //2010//

III. State Overview

A. Overview

Mississippi is a predominately rural state with approximately three-quarters of the 2.9 million state residents living in non-metropolitan areas. On the south, the state is bordered by Louisiana and the Gulf of Mexico; its western border is the Mississippi River; to the north is Tennessee; and to the east is Alabama. Mississippi's 82 counties contain 47,715 square miles. Although services are offered statewide, the Mississippi Delta area is at greatest risk for disparities in services to occur. However, all of Mississippi's 82 counties contain Designated Medically Underserved Areas.

Political power in Mississippi is distributed among a number of independent bodies. There is a sense of equitable, if not necessarily shared, influence over state functions between the Governor and the Legislature. Much of this shared influence stems from the organization of state agencies, some of which fall under the Governor's purview and some of which are independent agencies. For example, the Mississippi Development Authority (MDA), the Division of Medicaid, and the Department of Human Services (DHS) are executive branch agencies, while the Mississippi State Department of Health (MSDH) is independent. Independent agencies are governed by boards whose members are appointed by the Governor. The Governor maintains indirect influence through these appointments, but independent agencies must deal more directly with the legislature in negotiating budgets and significant policy changes. With the mix of executive and independent agencies, state agency heads do not function together as a cabinet, a situation that results in a number of horizontal power bases within the state government structure. Thus, economic factors continue to influence the Title V delivery system.

The racial composition of Mississippi residents is about 60% white and 37% African American. Mississippi has the largest proportion of African American residents of all the states. The Hispanic and non-citizen immigrant populations are small but growing, as Latinos move in to work for the poultry, forestry, and construction industries in the state. According to 2007 U.S. Census estimates, Hispanics comprise 2.1% of the state's population.

/2010/ In an effort to develop cultural competency within the agency, workshops were conducted by the MSDH OHDE during CY 2009 at eight of nine MSDH public health districts during which 1,300 staff were provided training in cultural competency by experts from the Morehouse School of Medicine. Workshops are scheduled for the remaining public health district and central office which will result in a total of approximately 2,200 MSDH staff that have received cultural competency training. The MSDH OHDE also employs a Latino Outreach Coordinator to provide guidance on multicultural perspectives including those of the Middle Eastern and Hispanic communities and to assist with the certification of MSDH translators. //2010//

A substantial share of employment in Mississippi is agricultural work. Because national economic statistics do not adjust for the local cost of living, these statistics probably overstate the relative level of poverty in the state. Also, according to 2007 Census estimates, 29.3% of Mississippi's children aged 18 years and under live at or below the federal poverty rate. Because of the high level of poverty, Mississippi faces challenges more severe than those of other states when it tries to craft policies to help low-income families. The state relies on a regressive tax system to generate revenues, with a high sales tax and a low income tax relative to national averages. It also relies heavily on federal funding sources to augment its budget.

/2010/ Concurrent with the rest of the nation, the economic downturn and recession has taken a toll on Mississippi. As unemployment increases and business declines, state revenues have dropped well below predictions resulting in budget reductions across all state agencies and further decreases in access to needed services. At the same time, demand for health care provided by safety net organizations such as community health

centers and MSDH clinics has increased.

The federal Health Resources and Services Administration (HRSA), in an effort to address increased demand coupled with less access, released over $300 million in economic stimulus monies from the federal American Recovery and Reinvestment Act to the nation's community health centers with Mississippi receiving over $6 million. This money is estimated to create additional service capacity for over 45,000 new patients and 22,000 new uninsured patients in Mississippi's 21 community health centers. Patients that visit community health centers are less likely to require hospitalization and visits to the emergency room which results in health care cost savings according to HRSA.

The MSDH Title V Program collaborates with state community health centers individually and through the MS Primary Health Care Association, an organization that represents community health centers in Mississippi. Examples of this collaboration are described in other narrative sections of the application/annual report. The MSDH and community health centers both provide gap-filling direct medical care services in all areas of the state. Federal funding such as Medicaid and SCHIP is critical to the continuation of the provision of medical care to the underserved populations in Mississippi served by each organization.

After a debate in the Mississippi legislature that centered on whether to hold a portion of stimulus funds in reserve or allow their current use by the Mississippi Medicaid Program, an agreement was reached that provided resources to the Medicaid program at a level that prevented potential personnel shortages at MSDH and underfunding and job losses at other state agencies.

There is a movement in this country towards preventive health services rather than after the fact treatment which tends to inflate health care costs that are already beyond the reach of many in Mississippi, including much of the MCH population. The MSDH understands the importance of prevention, especially in an era of shrinking state health care budgets, and emphasizes programs that prevent disease in order to reduce morbidity and mortality and decrease costs. Examples of preventive programs and services provided by the MSDH or its partners through a collaborative process that target our MCH population include children's immunizations, infant mortality reduction interventions [Delta Infant Mortality Elimination/Metropolitan Infant Mortality Elimination (DIME/MIME) projects], the placement of dental sealants on children's teeth, smoking cessation programs for pregnant women, and children's nutrition information. All of these examples are described in this application/annual report.

Other current MSDH initiatives include increased monitoring and reporting of influenza-like illnesses in response to swine flu cases that have been reported in Mississippi. The MSDH Title V Program works with district and county health departments to assure adequate monitoring and follow up as indicated. //2010//

/2009/ The 2007 immunization rate for two-year old children is one of the highest among the states at 80.5 percent, and should continue improving because of the development of a statewide immunization registry and outreach campaign. Other measures of child health and well-being are less encouraging. Compared with the nation as a whole, a greater percentage of children in Mississippi are born out of wedlock and live in single parent households. According to the 2007 Kids Count data, Mississippi ranks 45th of the 50 states in births to females aged 15-17 years. According to this same source, Mississippi had the highest percentages of low birth-weight babies, ranked 49th in infant mortality, 45th in child death rates, and 48th in teen deaths by accidents, homicide, and suicide. Mississippi, overall, was ranked last among the states in a composite rating of 10 selected measures of child well-being. However, despite these negative indicators, Mississippi is working diligently to incorporate several initiatives and/or programs aimed at addressing the risk factors that affect pregnant women, infants, children, adolescents,

and children with special health care needs (CSHCN) in our state.

The MSDH Office of Health Services, which is responsible for all Maternal and Child Health functions, conducts an annual District Program Review at each of the nine (9) public health districts. A team of health care professionals consisting of a nurse, nutritionist, social worker, and other health-related disciplines meets with district administrative staff to discuss the district's involvement in each Maternal and Child Health program. Programs such as Family Planning, Maternity, EPSDT, Newborn Screening, and Early Intervention are discussed to identify opportunities for improvement. District reviews were held in all nine public health districts over the last 18 months.

Although it has been four years since Mississippi's coastal counties were devastated by Hurricane Katrina, adequate health care is still a concern for Gulf Coast residents. While Vietnamese patients have decreased, there has been a greater increase in the number of Hispanic patients being seen by the health department(s). The influx of Hispanic patients produced a need for Spanish interpreters, which have been obtained to assist in helping the Hispanic population, especially in Harrison and Jackson counties. Some patients are not able to read their own language, and the addition of interpreter assistance has been instrumental in helping meet their needs. Because of a lack of health insurance or knowledge of the health system, Hispanic women often present late in their pregnancy which increases risks related to prenatal care. Once the newborn is delivered, mothers and their newborns continue to be served through WIC, Immunizations, and Family Planning clinics.

In addition to partnering with other providers to improve the provision of services to the MCH population, the MSDH currently provides an array of health education programs on a statewide basis through district and local county health departments. Health education is being provided to residents in the areas on poison prevention, child safety, immunization, infection control, nutrition, childhood obesity, fire safety, oral hygiene, and dental screenings. Many of these educational services are provided with the assistance of partners in communities, schools, and faith-based groups targeting youth and adolescents. //2009//

/2010/ On February 25, 2009, Mississippi Kids Count held its second annual summit at which the 2008 Mississippi KIDS COUNT Data Book was released. Data findings showed that Mississippi still ranks at or near the bottom of most major indicators of children's well-being. The latest data available from the Kids Count Data Center at the Annie E. Casey Foundation showed that Mississippi ranked 47th of 50 states in births to females 15-17 years of age, 49th in child death, and 50th in low birth weight, infant mortality, and overall rankings among all states. Adequate and stable MCH Title V funding is critical to improve the health indicators underlying these rankings and to move the health of Mississippi's children off the bottom of national state listings.

Access to MCH services is impacted by Mississippi's in-person (face-to-face) Medicaid/SCHIP recertification requirement which is considered a barrier to enrollment and recertification and may be partially responsible for the over 50,000 children dropped from Medicaid/SCHIP rolls. The State of New York's decision to eliminate face-to-face recertification for all Medicaid/SCHIP beneficiaries leaves only Mississippi with this requirement. In an effort to improve access to Medicaid/SCHIP services, the Mississippi House and Senate passed versions of a Medicaid technical amendments bill during the 2009 session with a provision that would end face-to-face recertification for children 16 years and under. The bill died in conference with the result that Mississippi is still the only state with the face-to-face recertification requirement.

The Mississippi legislature passed and the governor signed into law a fifty cents per pack cigarette tax increase which is expected to reduce tobacco use and save lives. Estimates show that youth smoking will decrease 8.5 percent which means that 16,000 children will be prevented from becoming addicted adult smokers. Additionally, close to 10,000 current

smokers are expected to quit and 7,600 Mississippians will be saved from smoking related deaths. Tobacco use is cited as the leading preventable cause of death in Mississippi. The increase in Mississippi's cigarette tax will help the MSDH to decrease the number of current smokers, prevent our residents from starting smoking, and reduce the number of people that die each year from smoking related illnesses. //2010//

B. Agency Capacity

The MSDH is the state agency responsible for administering the MCH Block Grant. These funds are allocated in the central office to the Offices of Women's Health and Child and Adolescent Health. The Children's Medical Program (CMP), the program of services for Children with Special Health Care Needs (CSHCN), is located organizationally in the Office of Child and Adolescent Health. All are located organizationally within Health Services (HS). (see organization chart at www.msdh.state.ms.us). Women's Health and Child and Adolescent Health provide services for the three major populations targeted by the MCH Block Grant: women and infants, children and adolescents, and children with special health care needs.

The MSDH operates a statewide network of local health departments and specialty clinics which serve the MCH population statewide. County level efforts are coordinated through nine public health districts. The District Chief Nurse oversees all public health nursing activities in the district and supervises the MCH/Family Planning Coordinator. Services include prenatal and postnatal care, well child and sick child care, as well as restorative services for CSHCN. This network allows the MSDH to address the needs of children and families, especially those with low incomes, in a family-centered, community-based and coordinated manner that ensures access and availability of quality health care.

Child/Adolescent Health Services

CMP

The CMP provides medical and/or surgical care to children with chronic or disabling conditions. Program services are available to state residents through 20 years of age who meet eligibility criteria. Conditions covered by the CMP include major orthopedic, neurological, and cardiac diagnoses, and chronic conditions such as cystic fibrosis, sickle cell anemia, and hemophilia. The program provides community-based specialty care through 12 clinic sites in which 209 specialty clinic sessions are held throughout the state, including a multi-disciplinary clinic centrally located in Jackson at the Blake Clinic for Children in the Jackson Medical Mall.

The CMP has a very strong link with the county health department system. Genetics/CMP staff are utilized to provide community based CMP application sites, screening and referral services, as well as a base of operations for central office staff when clinics are held at the community level. The CMP has developed partnerships with the University of Southern Mississippi Institute for Disability Studies (IDS), Cerebral Palsy Foundation, Cystic Fibrosis and Hemophilia parent support groups, Division of Medicaid, the University of Mississippi Medical Center, and the Choctaw Indian Health Services to ensure that all support services are coordinated for the patients when and where appropriate.

The CMP utilizes Advisory Committees to communicate with and receive feedback from health care providers and consumers. Advisory Committees includes specialty and sub-specialty physicians, dentists, physical therapists, other providers, and parents of CMP patients. Through this effort, providers are advised of program efforts to increase awareness regarding program services and efforts to assist CMP patients in finding a medical home. CMP also receives input from the Parent Advisory Committee.

/2010/ CMP has partnered with the University of Southern Mississippi IDS to utilize a Parent Consultant in a dual role. She serves as (2010) Parent Consultant and as the Family

to Family Health Information and Education Center Coordinator (F2FC). At CMP clinics, the Parent Consultant provides support services to families and regularly consults with professional clinic staff concerning patient and family concerns. Through her experiences with CMP as a parent, the Parent Consultant has a unique perspective on the services CMP provides to its parents. She provides input into program and policy decision making and is relied upon to share her experience and perspective in assisting CMP in involving families in decision making at all levels. //2010//

Adolescent Health Services

/2009/ Adolescent health information and services are provided through many existing programs within the MSDH service delivery system. Services include, but are not limited to: comprehensive health screenings and referrals, oral health screenings and referrals, nutritional assessment and counseling, genetic counseling, tobacco prevention, health promotion, safety and prevention education, social services, mental health referrals, immunizations, STD/HIV education, prevention and awareness, domestic violence, rape prevention and crisis intervention, and habilitative services for adolescents with special health care needs.

The MSDH Adolescent Health Services Program has established collaborations with partnering agencies and organizations to fulfill its mission to respond to the many issues impacting children, adolescents and young adults. Several critical initiatives include collaborating with: (a) Mississippi Department of Education (MDE) to strengthen communications and collaboration between MDE and MSDH to support and improve HIV, STD, and unintended and teen pregnancy prevention for school-aged youth and to improve school health and public health education policies and programs; (b) Mississippi Department of Mental Health to address an interagency system of care approach to deliver accessible and appropriate wrap-around community-based level services and treatment to children, adolescents and families with serious emotional, mental health disorders, substance abuse disorders and/or with juvenile justice system relations; (c) Mississippi Department of Human Services to deliver a wide range of community social services for vulnerable children, youth and their families in order to prevent and/or reduce service dependency, teen pregnancy, neglect and abuse and inappropriate institutionalization; (d) Mississippi Alliance for School Health to improve the health of school-aged children and youth through the promotion of coordinated school health services; and (e) Mississippi Department of Employment Security to deliver basic and appropriate health services to youth in order to prevent and reduce school dropout and youth delinquency rates.

The Adolescent Health Coordinator serves on numerous task forces and committees to raise awareness, educate, and plan interventions regarding critical health-risk behaviors and issues confronting children, adolescents, and young adults such as alcohol and drug abuse, bullying, violence and crime, obesity, injury and safety, teen suicide, school dropout prevention, juvenile delinquency, peer pressure and stress, unintended and teen pregnancy and parenting among adolescents.

Future health initiatives include establishing additional statewide, regional and community-based partnerships and trainings with middle and high schools, colleges and universities, national and state youth development organizations, such as United Way of America, 100 Black Men, Boys and Girls Club of America, Big Brother, Big Sister of America, Boy and Girl Scouts of America, Children's Defense Fund, Students Against Destructive Decisions (SADD), faith and community-based organizations, and youth-centered advocacy organizations and alliances to achieve the Healthy People 2010 objectives related to adolescent health. //2009//

Genetic Services

/2009/ The Genetics Services Program provides comprehensive services statewide for a broad range of genetic related disorders. Priority is given to prevention measures to minimize the effects of these disorders through early detection and timely medical evaluation, diagnosis and

treatment. Newborn screening is mandated by law in MS. In 2003, the MSDH expanded the screening panel to include the American College of Medical Genetics (ACMG) and March of Dimes (MOD) universal panel along with other disorders/diseases recommended by the MS Genetics Advisory Committee. The program provides newborn screening for phenylketonuria, hypothyroidism, hemoglobinopathies, and 37 other disorders to identify these problems early and allow for immediate intervention to prevent irreversible physical conditions, developmental disabilities or death. Professional and patient education is provided on a yearly basis to ensure that information is readily available to the population at risk, as well as to hospitals, physicians and other health care providers.

/2010/ The newborn screening program provided screening for 100 percent of all newborns in the state during 2008. In 2008, there were 1,673 patient follow up visits due to inadequate specimen collection, specimen rejection by the lab, or inconclusive test results. Follow-up counseling, referral for medical evaluation, and treatment were provided by the program for 100 percent of babies detected with heritable genetic disease/disorder through the screening program. //2010//

The CMP/Genetics team consists of a nurse and/or social worker and clerk in each of the nine public health districts. The team works with MSDH county and central office staff to assure adequate follow-up, care coordination and continuity of care for patients and their families.

Clinical services are provided primarily through referrals to the University of Mississippi Medical Center, Mississippi's only tertiary care center. Genetics satellite clinics are also routinely conducted in six public health districts in the state. These satellite clinics make genetic services more accessible for patients and families. The Genetics Services program will continue to increase awareness and education among community providers regarding newborn screening and reporting to the birth defects registry. Program staff will provide on-going education to providers on the follow-up of genetic disorders. //2009//

Early Intervention

First Steps is Mississippi's early intervention system for infants and toddlers with developmental delays and disabilities and their families. The MSDH is the lead agency that ensures an effective and appropriate implementation of IDEA, Part C. Other agencies such as the MS Departments of Mental Health, Education, Division of Medicaid, and Human Services collaborate with the MSDH and assist with the direct provision of early intervention services, referrals of potentially eligible infants and toddlers, and funding of the delivery of early intervention services.

A child with a developmental delay of 25% in any one developmental domain may be eligible for early intervention services. Infants and toddlers with conditions known to cause developmental delays such as genetic disorders (Down Syndrome), sensory impairments (hearing and vision), and other diagnosed conditions (autism) are automatically eligible for services. Also, a qualified provider through informed clinical opinion can establish eligibility. Under IDEA's child find component, the identification, location, and evaluation of infants and toddlers birth to age 3 is a shared responsibility of the MSDH under Part C and the MS Department of Education under Part B of the Act.

In 2005, the United States Department of Education/Office of Special Education Programs implemented an accountability system for states participating in Part C. A six-year plan with baselines, targets, activities, and timelines for fourteen indicators was developed by each state's program. The State Performance Plan and Annual Performance Reports must be made publicly available. They are posted on the First Steps home page of the MSDH website.

/2009/ The Early Intervention program's data system, called First Steps Information System (FSIS), has undergone recent changes to enhance the program's capability to collect and analyze data needed for the federal reporting requirements. Data are used for monitoring and managing

the program statewide and at the local level. As a direct result of changes to FSIS and referral procedures, the referral rate increased by 23% in a two-year period. //2009//

/2010/ The program will receive over $4 million in stimulus funding to address challenges of service provider shortages and timely service delivery. Plans are underway to determine needs and activities for spending the funding. //2010//

Early Hearing Detection and Intervention in MS (EHDI-M)

EHDI-M functions as part of the First Steps Program. EHDI-M is MSDH's designated program authorized to establish an early identification system for early hearing loss. EHDI-M implements a statewide family-centered comprehensive delivery system of developmentally appropriate services for infants and toddlers with hearing impairments, coordinated within the child's medical home. Universal newborn hearing screening is being implemented in all hospitals delivering greater than 100 infants per year. Aggressive follow-up is provided for infants referred from hospital screens to ensure the completion of diagnostic processes and timely referrals into the early intervention system.

Hearing Resource Consultants (HRCs) are contracted by the EHDI program to offer unbiased information regarding intervention choices to families. HRCs link families to support systems, resources, and to the Early Intervention system and participate in the Early Intervention evaluation and Individual Family Service Plan development.

Child Death Review (CDR) Panel

Legislation establishing a CDR Panel went into effect on July 1, 2006. The statute initially provided for the State Medical Examiner's Office to have administrative oversight of the CDR Panel. However, this oversight was moved by statute from the Medical Examiner's Office to the MSDH effective July 1, 2008. The CDR panel reviews data related to infant and child mortality. The primary purpose of the Panel is to reduce infant and child mortality and morbidity in Mississippi, and to improve the health status of infants and children age 0 to 17 years of age. The CDR Panel is composed of fifteen (15) voting members: the State Medical Examiner or his representative, a pathologist on staff at the University of Mississippi Medical Center, an appointee of the Speaker of the House of representatives, and one (1) representative from each of the following: the State Coroners Association, the Mississippi Chapter of the American Academy of Pediatrics, the Office of Vital Statistics in the MSDH, the Attorney General's Office, the State Sheriff's Association, the Mississippi Police Chiefs Association, the Department of Human Services, the Children's Advocacy Center, the State Chapter of the March of Dimes, the State SIDS Alliance, and Compassionate Friends. The chairmen of the review panel are elected annually by the panel members. (Due to space limitations, see update in IV. F. Other Program Activities)

Oral Health

The MCH Block Grant employs a dental director who monitors oral health needs in populations, develops policies, and plans and implements programs.

/2010/ Due to decreased funding, the Oral Health program no longer pays dentists to place preventive dental sealants. Instead, the MCH block grant supports a 0.5 FTE sealant program coordinator who recruits dentists to Federally Qualified Health Clinics (FQHCs) to provide sealants in school-based health centers at eligible schools. Sealant supplies are also provided. Our FY2010 goal is to enroll 12 FQHCs to participate in the dental sealant program and provide school-based preventive sealants to 5,000 children.

In May 2008, the CDC-funded School Fluoride Mouth Rinse Program was discontinued and the funding directed to increase the number of licensed dental hygienists employed from

five to eight. The expansion of hygienists enables the program to provide oral health assessment and caries risk determination, and deliver preventive fluoride varnish to moderate to high risk children in all nine public health districts. The program may submit reimbursement claims to Medicaid for eligible children for two fluoride varnish treatments in a 12 month period. The FY2010 goal is to enroll 20% of Head Start children in the fluoride varnish program and assist Head Starts to obtain comprehensive dental care for children.

The Oral Health program also supports a statewide oral health coalition called the Mississippi Oral Health Community Alliance (MOHCA). MOHCA appointed an Executive Board, adopted by-laws, completed an annual action plan, and is working to obtain tax-exempt status as a 501(c)(3) organization in FY2010.

Children diagnosed with cleft lip and/or palate or a craniofacial syndrome are eligible for coverage of procedures involving the oral cavity and related affected structures through the Children's Medical Program. In CY 2008, there were 332 CMP patients with the primary diagnosis of cleft lip/palate.

The program is collaborating with the MS Head Start Association to hold a Head Start Oral Health Workshop to create networks of dental providers capable of providing a full range of oral health services for Head Start and Early Head Start children. We are also partnering with the Tobacco Control program to promote tobacco cessation and awareness of the health risks associated with second-hand smoke exposure in Head Start programs. //2010//

Immunization Program

The Immunization Program provides and supports services designed to eliminate morbidity and mortality due to childhood vaccine-preventable diseases, such as diphtheria, tetanus, pertussis, polio, and measles. The program also provides services to prevent morbidity and mortality related to influenza and pneumonia. Services include vaccine administration, monitoring of immunization levels, disease surveillance and outbreak control, information and education, and enforcement of immunization laws.

The program assures that adequate supplies of vaccine are available for Vaccines for Children Providers. The program conducts an annual survey to determine the immunization status of children at 24 months of age, and several other surveys to determine the immunization status of other population groups. Additionally, staff develops education materials and provides training to immunization providers in the public and private sector and assists in the development of a statewide immunization registry.

/2010/ The Immunization Program collaborates with Division of Medicaid to ensure provider reimbursements for the Vaccines for Children Program. Additionally, the program has a Memorandum of Agreement with the Division of Medicaid to reimburse the agency for vaccines purchased through the CHIP Program. The Program also works closely with the American Academy of Pediatrics (AAP) and the American Academy of Family Physicians (AAFP) to educate and inform providers about vaccines.

The program collaborates with the MS Department of Education, MS Private School Association and the MS Catholic Dioceses to assure that all children enrolled in MS schools are vaccinated according to the MS School Immunization laws and guidelines. The program conducts immunization workshops, distributes memoranda/letters when changes occur, and reminds school administrators of immunization requirements. The staff also works with the Head Start and Child Care Directors by informing them what vaccines are required for childcare.

MCH staff supports the provision of immunizations in all of MSDH county health

departments and strives to increase immunization rates throughout the lifespan for children, adolescents and adults. According to the 2008 immunization survey of children at 27 months of age, 80.9 percent completed immunizations for measles, mumps, rubella, polio, diphtheria, tetanus, pertussis, Haemophilus influenzae type b, and hepatitis B. //2010//

/2010/ CDC Coordinated School Health Initiative

The MSDH Bureau of School Health and the MS Department of Education Office of Healthy Schools teamed to form the CDC Coordinated Approach to School Health Initiative to implement coordinated school health programs across the state and provide professional development and technical assistance in school districts with high levels of health disparities to improve the health of middle and high school students across the lifespan. Monitoring and assessment of effectiveness will focus on coordinated school health, physical activity, and nutrition programs; tobacco policy and cessation services; HIV, STD, and teen pregnancy prevention, and Youth Risk Behavior Surveillance activities. //2010//

Women's Health Services

The MSDH Office of Women's Health provides and ensures access to comprehensive health services that affect positive outcomes for women, including early breast and cervical cancer detection, domestic violence, prevention and intervention, family planning (reproductive health), and prenatal services to include Perinatal High Risk Management and Infant Service Systems to at risk pregnant women and infants. These services are designed for all women and their families at or below 185 percent of the Federal Poverty Level. The overarching goal is to provide early intervention and improved access to quality health care to target populations.

Breast and Cervical Cancer Program (BCCP)

The goal of the MSDH BCCP is to prevent early death and undue illness through early detection of breast and cervical cancer in women in the highest risk category. The target population for the program is uninsured, underinsured, and minority women. The target age range for mammography screening is 50-64 years and the target age range for cervical cancer screening is 40-64 years.

Services provided include screening and/or diagnostic mammograms annually for women 50 to 64 years of age; ultrasound; fine needle aspiration of the breast and breast biopsy, if indicated; annual Pap exams for women 18 years of age and older not already enrolled in a program that provides this service; colposcopy and biopsy, if indicated; follow-up and referral for abnormal Pap exams and/or mammograms; and educational programs for professional and the public.

/2010/ In Mississippi, it was estimated that 13,400 total new cases of cancer would be diagnosed in 2008 with 1,630 cases being breast cancer. This compares to year 2007 estimates of 15,190 total new cases of cancer diagnosed and 2,340 cases of breast cancer. According to MS Vital Records, total cancer deaths during 2007 were 5,930 with 389 of these deaths caused by breast cancer. The BCCP provided 7,266 mammography screenings and 4,220 Pap tests in CY 2008 compared to 6,477 mammography screenings and 3,820 Pap tests in CY 2007. //2010//

Domestic Violence, Rape Prevention and Crisis Intervention

The Domestic Violence Programs include Domestic Violence, Family Violence and Sexual Violence Prevention & Education and provide interventions across the state. The MSDH contracts with 14 domestic violence shelters and the 9 rape crisis centers across the state. Each shelter provides direct services to victims of domestic violence and their children. The shelters also

provide a public awareness campaign in an effort to make an impact on the cycle of domestic and sexual violence. Each rape crisis program provides primary prevention/intervention education to youth, teens, college students, and communities at large. When requested, MSDH provides brochures, pamphlets and educational materials on a statewide basis to the general public and other organizations.

Domestic violence shelters strive to meet the individual needs of every victim entering a shelter as a result of domestic violence. Program staff seeks to empower and enable through teaching life skills that promote non-violent responses which lead to a more peaceful life. Services include but are not limited to: temporary, safe housing; education regarding domestic violence; child care; transportation; job skills training; assistance in locating permanent housing; medical assistance; and transitional or second stage housing.

The sexual assault/rape crisis centers provide primary prevention and education activities, preventive services, as well as direct crisis intervention services to victims of rape and other forms of sexual assault. Primary prevention focuses on education to eliminate violence from sexual assault before it occurs. Although preventing the act from occurring is the desired outcome, prevention is not always an option. Centers spend a great amount of time providing direct service to victims of sexual assault including: court advocacy, confidential counseling, family intervention and follow-up services.

The new focus for rape crisis centers is primary prevention and education activities (preventing the act of violence before it occurs). These educational activities will focus on men and boys in an effort to change their beliefs and attitudes and increase respect for themselves, women and girls. The perception is that this approach will help to end or prevent the cycle of sexual violence against women.

/2010/ A total of 1,002 women and 1,140 children were provided shelter services (a decrease of three women and an increase of 11 children compared to the previous year). Nights of service totaled 67,099 (a decease from 72,294 served last year). Transitional housing was provided to 182 women and 278 children (a significant increase compared to 170 women and 184 children the previous year). Domestic abuse related calls totaled 16,244 and information and referral(s) calls totaled 22,618 (a decrease in 19,784 domestic abuse related calls and a decrease in 25,907 information/referral calls from last year). For children, the age group served the most ranged from age 7-13 (383), an increase compared to the age group served the most the previous year (age 3-6 with a total of 368). //2010//

Family Planning Program

The Family Planning Program promotes awareness and assures access to reproductive health benefits by encouraging individuals to make informed choices that provide opportunities for healthier lives. More than 60,793 Mississippians received comprehensive family planning services in CY 2007, and approximately 18,027 of those were age 19 years or younger.

/2010/ More than 61,400 Mississippians received comprehensive family planning services in CY 2008, and approximately 18,353 of those were age 19 years or younger. //2010//

The target populations are Teenage Females 19 and women ages 20-44 at or below 150 percent of poverty level. A fee system with a sliding scale is used where clients with an income at or below 100 percent poverty level are not charged for services. Reimbursement is sought for Medicaid eligible clients.

The family planning program provides:
1. Medical and non-medical contraception methods counseling
2. Medical examination and provision of contraceptive method
3. Pregnancy testing and counseling

4. STD/HIV testing & counseling

The family planning program also provides blood pressure screening, clinical breast exams, cervical cancer screening, follow-up of abnormal Pap smears and treatment, treatment for STDs, preconception care, sterilization, and infertility services. Access to other MSDH services such as WIC, immunizations, prenatal care, child health, and children's medical services is provided to family planning clients and their families as needed.

The Family Planning Program Demonstration Waiver was requested from Medicaid in 1999, approved in December 2002, and implemented statewide in October 2003. The waiver was designed to increase the number of women served and the length of time services would be available to them. An evaluation of the program expanded the Family Planning baseline data by examining inter-pregnancy (IP) intervals in the repeat birth population. In order to establish a comparison group for Family Planning, other MSDH programs were included in the evaluation.

The Family Planning Waiver Program represents a collaborative effort between the Division of Medicaid and the MSDH to increase the availability of family planning services to all women of childbearing age (13-44) with incomes at or below 185% of the federal poverty level who would not otherwise qualify for Medicaid.

/2010/ Since implementation of the Family Planning Waiver Program in October 2005, approximately 46,386 clients statewide have been enrolled through September 2008.

Additional collaborations include: activities with other health care providers, teachers, students, patients, potential clients, and organizations. This includes providing and assisting with presentations, health fairs, training, education through district level advisory information, educational committees and presentations, and networking with community and faith-based organizations that work with hard-to-reach populations. Family planning staff also participate with many different agencies, task forces, and coalitions to provide supportive services to various communities such as providing letters of support, assisting with grant writing, and serving on various coalitions and community councils.

A special inititative in two public health districts in the MS Delta provides adolescents and teens 18 years of age and younger with education and opportunities that will enhance their self esteem and provide them with the tools to make informed healthy decisions. //2010//

Maternity

MSDH Maternity Services Program aims to reduce low-birth weight, infant and maternal mortality, and morbidity in MS by providing comprehensive, risk-appropriate prenatal and postpartum care through county health departments.

/2010/ During CY 2008, approximately 18 percent of the women who gave birth in MS received their prenatal care in county health departments (compared to 19 percent in CY 2007). In FY 2008, 7,802 women received their prenatal care in county health departments compared to 8,356 in FY 2007 and 8,317 in FY 2006. Public health nurses, nurse practitioners, physicians, nutritionists, and social workers provide this cost-effective, comprehensive primary preventive care. The Special Supplemental Nutrition Program for WIC is a critical component of the maternity care effort. //2010//

A part-time, board-certified OBGYN continues to provide consultation statewide for the maternity and family planning programs. The public health team at the district and county level evaluates the maternity patient at each visit, using protocols which reflect national standards of care for maternity patients. Special emphasis is placed on the identification of high-risk factors and ensuring appropriate care to reduce or prevent problems. This includes arranging for delivery by an obstetrician at hospitals that provide the necessary specialized care for the mother and her

baby.

Perinatal High Risk Management/Infant Services System (PHRM/ISS)

PHRM/ISS is a comprehensive program consisting of a multidisciplinary team (MS licensed nurse, nutritionist or registered dietitian and social worker) established to improve access to health care and to provide enhanced services to certain Medicaid eligible pregnant/postpartum women and infants. The PHRM/ISS program provides targeted case management for high-risk pregnant and postpartum women and infants up to their first birthday. This is done through enhanced services to the pregnant woman and infant based on health risks identified during the medical risk assessment. Services include nutrition assessment/counseling, psychosocial assessment/counseling, health education, and home visits.

The goals of the PHRM/ISS program are to: reduce the complications of identified risks during pregnancy; reduce the occurrence of low birth weight infants, infant mortality or morbidity; encourage the use of cost effective medical care by appropriate and timely referrals; and discourage over utilization or duplication of costly services.

/2010/ In FY 08, the PHRM/ISS program provided services to 29,223 mothers and infants compared to 29,116 in FY 07. //2010//

Perinatal Regionalization

Regionalization of perinatal services is an effective strategy for decreasing neonatal and infant mortality and morbidity, with pronounced effects on mortality among Very Low Birth weight (VLBW) infants (<1,500 grams). Perinatal regionalization is a system of care that involves obstetric and pediatric providers, hospitals, public health, and includes outreach education, consultation, transport services, and back-transport for graduates from the Neonatal Intensive Care Unit.

Closing the Gap (CTG) on Infant Mortality: African American-Focused Risk Reduction

/2009/ During FY 09, CTG completed a three-year program funded by the HRSA through the Bureau of Maternal and Child Health. The purpose of CTG was to reduce significant disparity in African American infant mortality related to low birthweight, prematurity, and SIDS. The target areas included five counties in the Mississippi Delta (Bolivar, Coahoma, Leflore, Sunflower and Washington) and three counties in the Jackson Metropolitan area (Hinds, Madison and Rankin). The CTG pilot program investigated methods to reduce infant mortality through community outreach, professional education, research and surveillance.

/2010/ CTG outcomes included research findings and publications that documented the need to implement preconception and interconception care programs among high risk Mississippi women. (see MIME/DIME below). //2010//

Internal Infant Mortality Task Force

In addition to the CTG program, other infant mortality activities have been initiated. In August 2007, the new State Health Officer called for the assembly of an internal infant mortality task force. This task force was charged with identifying immediate or near future interventions that could be implemented right away to begin reducing MS infant mortality. Task Force participants represented all nine public health districts and were a dynamic multidisciplinary team representing administrators, data analysts, community health educators, directors, epidemiologists, various nursing positions, nutritionists, physicians and social services.

The Internal Infant Mortality Task Force developed the following recommendations for addressing infant mortality in MS and agreed that if sufficient support was available, the recommendations

listed below could be implementedstatewide.

1. Expedite Medicaid application process by placing Medicaid eligibility workers in local health clinics to facilitate earlier entry into prenatal care
2. Conduct statewide Needs Assessment of available MSDH services and staffing capabilities to support those services (i.e., prenatal care, PHRM/ISS, mortality reviews, post partum home visit other than PHRM, hospital visiting), along with further analysis of infant mortality data
3. Expand staffing to support delivery of infant mortality related services
4. Provide staff education and development activities
5. Provide education and outreach at professional and community levels

Some of these recommendations were immediately initiated. For example, A CDC epidemiology team worked with MSDH Health Services to conduct in depth analysis of infant birth linked with death files. And as of February 28th, 2008, the number of days per month that a Medicaid eligibility worker was present within a local health department increased by 212%.

Delta Infant Mortality Elimination (DIME) Project

The DIME project's primary focus is to reduce infant mortality in the MS Delta. DIME targets gaps in women's and infants' health services in the 18 counties of the Delta Health Alliance initiative. DIME is a multidimensional, multicollaborative effort including the MSDH, the University of Mississippi School of Medicine, the University of Mississippi School of Nursing, and the Jackson State University College of Public Service.

The DIME project proposes to accomplish its goal of decreasing infant mortality in the MS Delta by: 1) Filling gaps in healthcare services for women and infants; 2) Increasing efficiency and utilization of available healthcare services for women and infants; and 3) Enhancing knowledge and skills of healthcare consumers and providers in the Delta.

The DIME project strategically assembles partners to increase the number of providers in the Delta, enhance case management and follow up services, initiate post-partum home visitation activities and increase access to women's healthcare and chronic disease management. An additional DIME component is coordinated infant death review conferences among health department and local providers to gain insight on opportunities to improve outcomes for infants and families of the Mississippi Delta. Outreach and educational services will be provided at individual, community, and professional education levels. //2009//

/2010/ Metropolitan Infant Mortality Elimination (MIME) Project

The MIME project is the sister project of the DIME program. The MIME project is being piloted in the Jackson Metropolitan Area utilizing the same interpregnancy care project components used in the DIME project.

The DIME and MIME projects provide rural and urban perspectives of interpregnancy care implementation strategies in MS. After extensive research design and evaluation planning, DIME and MIME were finalized and multi-agency institutional review board approval was obtained. Enrollment of participants was initiated in mid-February 2009 and the first participant was enrolled on only the third day of recruitment. //2010//

Pregnancy Risk Assessment Monitoring System (PRAMS)

/2009/ MS PRAMS is part of the CDC initiative to reduce infant mortality and low birth weight deliveries in MS. It is an ongoing, population-based, state-specific source of information on selected maternal behaviors and experiences that occur before and during pregnancy and during a child's early infancy.

Since the start of data collection, PRAMS continues to successfully survey mothers throughout the state of Mississippi. PRAMS surveys approximately 176 mothers a month. PRAMS received its first 2007 data batch in June of the same year. The state's response rate is required to be 70 percent of the total sample size as the epidemiologically valid threshold.

All PRAMS reports and raw data for 2004 and 2006 births have been submitted to CDC. The data collection for 2005 was halted due to Hurricane Katrina. The data analyses for 2004 will be published in a fact sheet by summer 2008. The 2006 data collection ended in May of 2007 and is currently being analyzed.

Phase Five of the PRAMS survey began January 14, 2004 and will end December 2008. The MSDH PRAMS staff submitted a poster presentation entitled "2003 PRAMS Data Reporting versus Birth Record Reporting: A Statewide Comparison of Three Variables Using Cronbach's Statistics" at the 2006 Annual Maternal and Child Health Epidemiology Conference in Atlanta, GA.

PRAMS staff collaborated with the Dental and STD/HIV programs to ask state specific questions of concern to add to the Phase six (6) survey which will begin in January 2009. In addition, the PRAMS Steering Committee provided input at their February 28, 2008 meeting regarding the selection of specific standard questions that will be added to the new PRAMS survey. The new Phase Six survey questions are currently being reviewed by CDC staff, and will be sent back for final approval by the MS Prams Program staff. //2009//

Office of Tobacco Control (OTC)

/2009/ The mission of the MSDH OTC is to promote and protect the health of all Mississippians by reducing tobacco-related morbidity and mortality. The program accomplishes this by utilizing a systemic approach to tobacco prevention and control. Program components include: state and community interventions, health communication interventions, tobacco cessation interventions and surveillance and evaluation. Each program component is developed and implemented based on evidence-based strategies and the recommendations outlined in CDC Best Practices-2007.

Since its inception in July 2007, the MSDH OTC has worked diligently to develop the statewide and comprehensive tobacco education, prevention and cessation program. Through CDC Cooperative Agreement funds, the program has partnered with the MSDH Office of Preventive Health, Chronic Disease Bureau, to establish chronic disease coalitions that educate communities on cardiovascular disease, diabetes, asthma and tobacco use. The program has furthered its efforts to enhance established coalitions by supporting the MSDH/American Lung Association of Mississippi's district-level asthma coalitions.

/2010/ OTC partners with Oral Health to promote tobacco cessation and awareness of the health risks associated with second-hand smoke exposure in Head Start programs and WIC to distribute tobacco awareness brochures. WIC certifiers also discuss smoking related issues with applicants. //2010//

Office of Preventive Health (OPH)

The Office of Preventive Health's mission is to educate, prevent and control chronic diseases and injury by promoting optimal health through advocating for community health awareness, policy development, coordinated school health, faith-based and worksite wellness initiatives. The OPH also collaborates with public, private and voluntary organizations; establishes and participates in coalitions, task forces and partnerships; and obtains funding for planning and program development. Programs within OPH that are designed to improve the health of Mississippians are referenced in the programs below.

Cardiovascular Health Program priorities are to: control high blood pressure, educate on signs

and symptoms, improve emergency response, eliminate health disparities, develop culturally-competent strategies for priority populations and develop population-based strategies.

Comprehensive Cancer Control Program priorities are to: establish a statewide system for comprehensive cancer control in MS, develop a coordinated response to the excessive cancer burden in MS using data and input from interested citizens and to identify and prioritize the implementation of the state CCC plan.

Diabetes Prevention Program priorities are to: identify and monitor the burden of diabetes, develop new approaches, implement specific measures and coordinate and integrate efforts to reduce the economic and social consequences of diabetes.

Community Health Program priorities are to: promote population based strategies to impact policy and environmental changes that will positively affect the risk factors of chronic disease.

Injury/Violence Prevention priorities are to: promote bicycle/pedestrian safety awareness, provide bicycle/pedestrian training to key stakeholders, reduce the incidence of death and injuries attributed to fires in high risk communities, enhance infrastructure for injury prevention and control in Mississippi, and promote injury prevention policy. //2009//

Sudden Infant Death Syndrome (SIDS)

The purpose of the MSDH SIDS program is to provide a statewide system for the identification of SIDS deaths, and to offer counseling and referral services as indicated for families with sudden unexplained infant deaths. The program also provides assistance in the campaign to educate the general public on SIDS risk reduction.

In 2006, 68 infants died from SIDS, a decrease from the 91 infants who died from SIDS in 2005. In CY 2006-2007, SIDS trainings were conducted at childcare facilities in Hinds County utilizing a resource kit for reducing the risk of SIDS developed by the National Institutes of Health. MSDH also provided SIDS health education materials at SIDS trainings sponsored by the National Institute of Child Health and Human Development. The program mails out monthly "What You Need to Know About SIDS" brochures to hospitals statewide. From January-June 2008, the program provided 7,000 brochures to hospitals and community health fairs, and provided trainings at 15 childcare facilities in Warren, Claiborne, and Hinds counties. The program has also developed and provided SIDS display boards to social workers in all nine health districts to use at outreach activities.

Laws and Authorizations:

State laws that guide the MS public health system and provide authorization for programs and policies are attached for review.
An attachment is included in this section.

C. Organizational Structure

/2009/ In December, 2007, the newly established 11 member Board of Health selected interim State Health Officer, Dr. F. E. Thompson, Jr. as the new state health officer for the State of Mississippi. Prior to serving as the interim state health officer, Dr. Thompson was Mississippi's State Health Officer from 1993-2002.

Also, Dr. Mary Currier, who was serving as interim State Epidemiologist, was selected as Mississippi's State Epidemiologist. Dr. Currier served as Mississippi's State Epidemiologist from 1993 to 2004. Having Dr. Currier as our State Epidemiologist is a giant stride toward rebuilding the epidemiological capacity of the MSDH, which is critical to protecting the public's health.

The Office of Health Services directly supports the agency's mission to protect and promote the health of Mississippians through a variety of programs designed to prevent disease, maintain health, and promote wellness for Mississippians of all ages. The Office of Health Services has two primary areas of focus: Health Maintenance and Health Promotion. The primary goal of Health Maintenance is reducing infant mortality rates. Health Maintenance strives to improve healthcare services for women and infants, increase efficiency and utilization of available services, and enhance knowledge and skills of both consumers and providers of healthcare services. Health Promotion encourages achievement of optimal health and physical well-being while seeking to minimize risks for chronic disease and injuries. Health Promotion programs benefit Mississippians who want to improve and secure their health. Together, the two areas provide a comprehensive approach to improving health outcomes, which in turn leads to reduced morbidity and mortality among Mississippians. //2009//

BIOGRAPHICAL SKETCHES

Daniel R. Bender, MHS, currently serves as the Director of the Office of Health Services. Mr. Bender was the Director of the Genetics Program from 1983 to 2000, where he worked toward the passage of laws mandating newborn screening for PKU, T4 (TSH), Hgb and Galactosemia. Mr. Bender started nine satellite genetic clinics in the state and started the first genetics database in Mississippi. He also developed the Mississippi Birth Defects registry. Mr. Bender's medical experiences include registered Emergency Medical Technician for Baldwin Ambulance and Director of Rankin County Emergency Medical Services. His education includes a Bachelor of Science Degree in Special Education and Master's Degree in Health Science. Mr. Bender has made many presentations which include Health Care for the Poor, the National Neonatal Screening Symposium, and the American Public Health Association.

LeDon Langston, MD, is a Board Certified OB/GYN physician currently serving as medical consultant to the Office of Women's Health in Health Services. Recently retired from 25 years of private practice at Southwest Mississippi Regional Medical Center in McComb, Mississippi, he joined the MSDH in February, 2001. He brings with him experience of 6000 deliveries and 3000 gynecological surgeries and serves as a bridge between private and public health practices. Dr. Langston is a former flight surgeon in the United States Air Force. He is a former member of the Mississippi Medicaid Medical Advisory Committee; President of the Mississippi OB/GYN UMMC Society; and the Medical Policy Advisory Committee for Blue Cross/Blue Shield of Mississippi. His present interests include the Teen Pregnancy Prevention and Breast and Cervical Cancer Programs.

Lynn Walker, M.D., is a board certified pediatrician who provides consultation to the Mississippi State Department of Health. She has twenty years of experience in general pediatrics and pediatric pulmonology, especially in the care of children with chronic illness and special health care needs. Dr. Walker joined the department in September, 2006 and is a link between the community health care providers, tertiary care providers and the Department of Health. Special interests include newborn screening and care of children with special health care needs.

Louisa Young Denson LSW, MPPA, CPM, is currently the Director of the Office of Women's Health for the Title V program within the Mississippi State Department of Health. Ms. Denson has served in various capacities in public health. Previously, she served as the Director of Disparity Elimination, Director of Minority Affairs, Office Systems Advisor for all clerical staff with the agency, Immunization Representative for 11 counties in District V, Hinds County Office Manager (which consisted of 11 clinics), Director of the Mary C. Jones Clinic, Public Health Advisor for the Sexually Transmitted Disease Program and a clerk in Vital Records and Statistics. Ms. Denson has a Master's in Public Policy and Administration, Bachelor's degree in Social Work, and is a licensed social worker. She has also completed the Certified Public Managers Program with the State Personnel Board.

Geneva Cannon RN-C, MHS, is Director of the Office of Child and Adolescent Health. Ms.

Cannon has over twenty years of experience as a pediatric nurse in critical care, public health, and administration. She was employed with the MSDH in the late 1980's and early 1990's as a nurse with the Genetics Program and later as a nurse consultant with the Office of Child and Adolescent Health. Her career also includes working as Director of Licensure and Practice with the Mississippi Board of Nursing. Prior to her current position, she worked as the Program Coordinator in the planning and implementation of the separate insurance plan for the state's Children's Health Insurance Program.

Lawrence H. Clark is the Director of the Children's Medical Program (CMP), Mississippi's Title V Children with Special Health Care Needs (CSHCN) program. He has over 25 years of supervisory and management experience. He has worked with the Allstate Insurance Company's Regional Office in Jackson, Mississippi, and their corporate headquarters in Chicago, Illinois. He has 13 years of managerial experience with the Mississippi Development Authority, formerly known as the Mississippi Department of Economic and Community Development. Before joining the MSDH staff, he was employed with the Mississippi Department of Education, Office of Special Education where he managed several statewide initiatives.

Kathy Gibson-Burk is the Director of the Office of WIC with the MSDH. She came to the Department of Health in 1994 as the District Social Work Supervisor for the West Central Public Health District V. In 1997 she was promoted to the State Social Services Director; and in 1999 she received another promotion as the Deputy Field Services Director. She has over 22 years of service and management experience in state government, having worked 13 years with the Mississippi Department of Human Services. She earned a Bachelor's of Social Work degree from Mississippi University for Women, and a Master's of Social Work degree from the University of Southern Mississippi. She also received the Certificate of Achievement from the Tulane School of Public Health and Tropical Medicine for completion of the South Central Public Health Leadership Institute and is a graduate of the Certified Public Manager's Program through the Mississippi State Personnel Board.

Juanita Graham, MSN, RN is the Health Services Chief Nurse. Juanita serves as a nurse consultant to the five offices of Health Services including WIC, Women's Health, Child & Adolescent Health, Preventive Health, and the Office of Health Data & Research. Juanita participates in a variety of activities including grant writing, continuing education for nurses, logic modeling, and research. She holds both Bachelor's and Master's degrees in Nursing Science from the University of Mississippi. She teaches and develops online courses for several nursing and healthcare administration programs and holds a number of adjunct faculty appointments. Juanita is a member of the American Public Health Association, an officer and state delegate for the Mississippi Nurses Association, and a chapter board member and national delegate for the Sigma Theta Tau International Nursing Honor Society. She has given several state and national presentations on a variety of topics ranging from logic modeling to infant mortality.

Benny Farmer became the financial director of Health Services on May 1, 2003. He has considerable experience with grants and budgeting due to working in the MSDH Bureau of Finance and Accounts for sixteen years, first as an accountant in various areas, and then as director of the Division of Budgeting/Purchasing/Grants. He holds a Bachelor's degree in accounting from the University of Southern Mississippi.

Virginia L. Green, MD, began working with Children's Medical Program (CMP), Mississippi's Title V CSHCN program, in 1986, as Pediatric Consultant. Other pediatric experience includes: private practice in Montgomery, AL, 1980-1983; pediatrician for District V, Mississippi Department of Health, 1983-1986; pediatrician and Assistant Professor of Pediatrics, Department of Pediatric Gastroenterology, University of MS Medical Center (UMC), 1991 -1993. She also served as a review pediatrician for Mississippi Disability Determination Services (DDS), reviewing childhood cases for eligibility for Supplemental Security Income (SSI) and Medicaid, 1991 -1993. In 1994, she returned to CMP the Program's Medical Director. She has served on several committees relating to children with special health care needs and continues to serve on the UMC Visiting

Teaching Faculty and on the Board of Directors for the Spina Bifida Association of MS.

/2009/ Larry L. Smith, MS, PhD, is a research biostatistician currently assigned to the Office of Health Data and Research of the Mississippi State Department of Health. In addition to providing support to various programs within the MCH Title V program, he is a data/analyst for the Mississippi State Department of Health Pregnancy Risk Assessment Monitoring System (PRAMS) and Women, Infants, Children (WIC) program. Dr. Smith's research interests include health survey data analysis and the influence of behavioral stressors on maternal child health outcomes. He has published in peer-reviewed journals. He has a Master of Science degree in Engineering Science with environmental concentration from the University of Mississippi in addition to a Master of Science and Doctor of Philosophy in Preventive Medicine/Epidemiology from the University of Mississippi Medical Center in Jackson, MS. //2009//

Lei Zhang, MS, MBA, PhD, is the director of the Office of Health Data & Research . He is the principal investigator of the Mississippi Asthma Program and the Mississippi Pregnancy Risk Assessment and Monitoring System (PRAMS). In addition, he oversees all aspects of data collection and data analysis within Health Services. Dr. Zhang's research interests include health survey data analysis and spatial investigation using GIS. He has published several articles in peer-reviewed journals. In addition, he has given numerous presentations in national and local conferences. Currently he is a member of both the American Statistical Association and the American Public Health Association.

Dr. Nicholas Mosca is State Dental Director for the Mississippi Department of Health and Clinical Professor of Pediatric and Public Health Dentistry at the University of Mississippi Medical Center School of Dentistry. A 1987 graduate of Loyola University School of Dentistry, Dr. Mosca completed a two-year General Practice Residency at Charity Hospital Center in New Orleans. From 1989 to 1999, he served as director of the Hospital Dental Clinic at the University of Mississippi Medical Center and later served as clinic coordinator for the Jackson Medical Mall Outpatient Dental Clinic. Dr. Mosca is a fellow of the American College of Dentists and the Rho Sigma Chapter of Omicron Kappa Upsilon Honorary Dental Society.

In 1996, Dr. Mosca completed the Harry W. Bruce Jr. Legislative Fellowship at the American Dental Education Association (ADEA). In 2005, he completed a Department of Health and Human Services Primary Care Health Policy Fellowship. From 2004 to 2007, he served as a member of the National Oral Health Advocacy Committee for ADEA and the American Association of Dental Research. From 2005 to 2007, he served as co-chair of the Oral Health Policy Committee for the American Association of Public Health Dentistry. Presently, Dr. Mosca serves as secretary on the Executive Committee of the Association of State and Territorial Dental Directors, an affiliate of the Association of State and Territorial Health Officers.

/2009/ Donna Speed, MS, RD, LD serves as the Nutrition Services Director and coordinator for the Fruits & Veggies-More Matters program for the state. She has 30 years of experience, much of it working with the public and community in the area of disease prevention and wellness. Donna works with the WIC program and the Department of Education to promote a healthier lifestyle for women, infants, and children. She has served as an advisor to the Office of Healthy Schools during the time that legislation was passed for healthier vending guidelines, for nutrition education, and physical activity in the schools in Mississippi. She is a frequent speaker for professional and community events. She serves as the education/nutrition chairman for Mississippi Chronic Illness Coalition, the Mississippi Comprehensive Cancer Control Program, Mississippi Action for Healthy Kids, the School Nutrition Action Plan, Mississippi Alliance for School Health, Lead Prevention and Elimination Program and is on several committees with the National Partnerships of Fruits & Veggies-More Matters Coordinators. Her interests include infant and pediatric nutrition and promoting a healthier lifestyle for the adult population.

Terry Beck, MSW, LCSW, the Interim Public Health Social Work Director, has some forty years of public health experience at all levels of practice. He holds the Master of Social Work Degree and

is credentialed at the Licensed, Certified Social Work level (LCSW). The Social Work Director provides professional social services perspective and consultation to the director of Health Services regarding policy development, standard setting, and the establishment of service priorities in addition to oversight, consultation and professional supervision to nine social services regional directors and three state level social work consultants. //2009//

/2010/ John Justice, MHSA, was appointed in February 2009 to serve as the MCH Block Grant Coordinator for the Mississippi State Department of Health. John began his employment with MSDH in August 1992 as a Public Health Environmentalist in Hinds County (Jackson) Mississippi. In 2004, he joined the MSDH Office of Oral Health as the Fluoridation Administrator where he oversaw the Mississippi Community Water Fluoridation Program. In 2005 and 2006, John received national awards from The Centers for Disease Control & Prevention (CDC), the Association of State & Territorial Dental Directors, and the American Dental Association for his work to increase the proportion of population in Mississippi that receives the benefits of fluoridated water. In 2006, he served on a CDC Expert Panel on Engineering and Administrative Recommendations for Water Fluoridation and has given over 100 presentations on water fluoridation and oral health to a diverse group of stakeholders including city councils, boards of directors of water associations, service club organizations, and members of the public health community. //2010//

D. Other MCH Capacity

At the state level, the Office of Health Services (HS) administers programs that provide services to the MCH/CSHCN population.
Within HS there are three offices that serve this population. They are listed below with the Central Office FTE of each:

Office of WIC 12
Office of Women's Health 22
Office of Child/Adolescent Health, including CSHCN
and First Step Early Intervention System (FSEIS) 72

Each office, through the MCH Block Grant, supports services to women and infants, children and adolescents and CSHCN through local county health departments and speciality clinics. The MSDH provides case management, childhood immunizations, well-child assessments, limited sick-child care, and tracking of infants and other high-risk children. Services are targeted towards women and children whose family incomes are at or below 185 percent of the federal poverty level. The MSDH provides services to more than 120,000 children annually. Adjunct services such as the First Steps Early Intervention System (FSEIS), Genetic Screening, WIC, and the Children's Medical Program are important components of the comprehensive Child/Adolescent Health Program. Services are provided through a multi-disciplinary team approach including physicians, nurses, nutritionists, and social workers, and provide early identification of potentially disabling conditions and linkages with providers necessary for effective treatment and management. The MSDH provides services to women and infants through its family planning, maternity, and Perinatal High Risk Management/Infant Services System (PHRM/ISS) programs.

Children and adolescents are targeted for periodic health assessments and other services appropriate for their age and health status. Those services may include, but are not limited to:

(a) immunizations;
(b) genetic screening and counseling;
(c) routine and periodic screening, diagnosis and treatment for EPSDT
eligible infants and children;
(d) well-child and sick-child care;

(e) vision and hearing screening;
(f) WIC services;
(g) counseling regarding: reproductive health issues, alcohol,tobacco, and substance abuse, and sexually transmitted diseases;
(h) comprehensive developmental services from child birth to age 3;
(i) dissemination of information on the benefits of protective dental sealants to families of children receiving health department services; and,
(j) referral and case management for treatment of conditions where services are not readily available; and,
(k) PHRM/ISS

Children and adolescents, including CSHCN, receive direct health care services such as interventions for high risk individuals, case management, care coordination, primary and preventive care, health education and counseling.

The CMP has developed very effective lines of communication with the UMMC, the March of Dimes, Cerebral Palsy Foundation, Cystic Fibrosis Foundation, and the local chapter of the Hemophilia Foundation to make sure that all support services are coordinated for the patients where and when appropriate.

The CMP also maintains a major link with health care providers through the CMP Advisory Council, which includes physicians, parents, hospital representatives, anesthesiologists, physical therapists, social workers and other health care providers. Through these resources, providers are advised of the expanded effort to provide services to disabled children under sixteen (16) who receive SSI benefits under Title XVI. The Children's Medical Program has led the way to coordinate communication between CMP, Social Security, and the State Disability Determination Office.

The CMP works to develop and strengthen lines of communication between all state agencies that provide assistance to CSHCN and to the blind and disabled population under sixteen (16) years of age. This includes invitations to CMP Advisory Council meetings, both parent and professional.

The Title V agency maintaines a toll-free telephone line in the Office of Women's Health. The line provides assistance to clients seeking information about MCH services, family planning, Medicaid, and other services. This valuable tool encourages early entry into prenatal care and further links the private and public sectors. Information about the line is publicized through a newsletter of the Mississippi Chapter of the American Academy of Pediatrics, brochures, posters, and a Teen Help Card.

Toll-free numbers in the agency which are directly related to services for the MCH/CSHCN population include a Genetics/Early Intervention line, an HIV/AIDS line, and a CMP line.

E. State Agency Coordination

\There are various organizational relationships that exist between the MSDH and other human service agencies that work to enhance the capacity of the Title V program. Examples of MSDH's coordination efforts with other human service agencies are as follows:

March of Dimes
The MSDH partners with the March of Dimes to increase the awareness of folic acid as it relates to birth defects. The March of Dimes launched a campaign to raise awareness of the growing problem of prematurity and to decrease the rate of preterm births. Premature infants are more

likely to be born with low birthweight and suffer mild to severe disabilities and/or death. Prematurity is the leading cause of infant death before the first month of life.

Mental Health
The MSDH collaborates with the MS Department of Mental Health, Division of Children and Youth Services to provide a comprehensive community-based mental health service system for children and adolescents. The Division serves as the lead agency responsible at the state level to improve the availability of and accessibility to appropriate, community-based service. A collaborative team of the Mississippi Department of Mental Health Comprehensive Mental Health Centers, the State Level Case Review Team, several local Multidisciplinary Assessment and Planning (MAP) Teams, and other child-serving agencies and task forces assist children, youth and family access the system of care.

The State Level Case Review Team operates through an interagency authorization agreement to review cases of children and youth up to age 21 with serious emotional and behavioral problems and or serious mental illness for whom adequate treatment and or placement cannot be found at the county or local level, and for whom any single state agency has been unable to secure necessary services through it own resources. Before cases are referred to the State Level Case Review Team, all cases concerning children and youth (age 5 to 21) who have a serious emotional and/or behavioral disorder or serious mental illness; and who are at immediate risk for an appropriate 24 hour institutional placement due to lack of access to or availability of needed services and supports in the home and community are reviewed by the Local-Level Multidisciplinary Assessment and Planning (MAP) Team. After having exhausted all available services and resources in the local community and/or in the state, cases are then referred to the State Level Case Review Team.

/2010/ In 2007, homicide and suicide, along with accidents, accounted for the top three causes of deaths for teenagers aged 15 to 19 years. Therefore, intentional youth violence continues to be a desired target of educational programming and intervention implementation. The Injury and Violence Prevention Program has partnered with the Mississippi Department of Mental Health to implement school-based suicide prevention efforts in areas of the state with the highest frequency of teen suicides. //2010//

Alcohol and Drug Prevention Programs
The Born Free project, which originated with the MSDH, networks available community resources for the provision of services to substance-involved pregnant women and their infants. Other agencies involved in the Born Free network include: (a) the University of Mississippi Medical Center; (b) Marian Hill Chemical Dependency Treatment Center; (c) New Life for Women (housing); (d) Catholic Charities (provides direct primary treatment services and transitional program services); (e) community health centers; (f) Jackson Recovery Center; (g) state mental health centers and state hospital; (h) parole officers and the court system; and, (i) sexual assault and domestic violence shelters and other treatment centers. Born Free is now administered by Catholic Charities.

The Mississippi State Department of Health Adolescent Health Coordinator actively serves on the Mississippi Department of Mental Health Alcohol and Drug Abuse Advisory Council in order to advise and support prevention and treatment programs aimed at reducing alcohol and drug abuse among adolescents and young adults. The Council promotes and assists the Bureau of Alcohol and Drug Abuse with developing effective youth prevention programs; providing input on the development of the annual State Plan for Alcohol and Drug Abuse Services; participating in the Department of Mental Health's peer review process; and promoting the further development of alcohol and drug treatment programs at the community level.

/2010/ Healthy Linkages
Recently, MSDH, University Medical Center, and the federally qualified community health centers in Mississippi entered into an agreement that initiated the Healthy Linkages

project. Healthy Linkages is an effort to improve coordination of care and strengthen the service referral process between the participating organizations in order to improve outcomes for the maternal and child health population in Mississippi. //2010//

First Steps Early Intervention System
The FSEIS is structurally located within the Office of Child and Adolescent Health, and has established an Interagency Coordinating Council to bring together the state departments of Mental Health, Education, and Human Services; the Division of Medicaid; universities, providers of services, and others to develop a comprehensive system of family-centered, community-based, culturally-competent services. Local interagency councils and stakeholder groups support the planning, development and implementation of the system at the community level.

Mississippi Statewide Immunization Program
The MSDH Statewide Immunization Program is primarily funded by the Centers for Disease Control and Prevention, but MCH funds are used to support some staff in local health department clinics. A statewide coalition has been established, which is composed of health care professionals (organizations and individuals), immunization providers, community-based organizations, social/civic groups, lay people, and others with an interest in improving the immunization status of Mississippi's children. This broad-based group provides the framework for promoting the implementation of the immunization monitoring and tracking system in non-health department clinics.

Department of Human Services (DHS)
DHS provides services that include case management, child care for the developmentally disabled, services for the chronic mentally ill, abstinence education, and treatment for alcohol and chemically dependent adolescents.

DHS Office of Children and Youth uses funds for day care, while the Division of Aging and Adult Services uses Social Services Block Grant (SSBG) funds for home health aides, ombudsmen services, transportation for elderly, case management for adults, adult day care, home delivered meals for adults, and respite care. The MSDH no longer receives SSBG funds from the DHS to assist in its efforts to provide needed contraceptive services to teens, however, a representative of the MSDH is a member of the DHS Out-of-Wedlock Task Force.

DHS administers the federal Child Care Development Block Grant (CCDBG) which has two basic component areas. The provision of actual child care services comprises 75 percent of the budget. The Quality Child Care Development portion of the budget provides funds for training of child care providers, improvements to day care centers, and media centers. Some CCDBG funds are provided to the MSDH for child care facilities licensure.

Division of Medicaid
The Division of Medicaid is a key player in the reimbursement for services to patients seen in Mississippi State Department of Health (MSDH) clinics. In addition to a cooperative agreement, which allows billing for special services provided to Perinatal High Risk Management/Infant Services System (PHRM/ISS) and other non-high risk patients, the MSDH assists Medicaid in assessing pregnant women and children for Medicaid and CHIP eligibility using MSDH staff and out-stationed eligibility workers. Medicaid staff and MSDH staff meet quarterly to discuss PHRM/ISS progress and concerns.

The Mississippi State Department of Health Office of Child and Adolescent Health collaborates with Mississippi Division of Medicaid to support the MYPAC (Mississippi Youth Programs Around-the Clock) , a home and community-based Medicaid waiver program that provides an array of services for youth with severe emotional disorders. The program provides alternate services to traditional Psychiatric Residential Treatment Facilities (PRTF) services.

Community Health Centers/Primary Health Care Association

A primary care cooperative agreement with the Bureau of Primary Health Care has been administered by the MSDH since 1985. The cooperative agreement provides a mechanism for joint perinatal planning and provider education between the state MCH program and the 21 community health centers (CHCs). Perinatal providers are placed in communities of greatest need through a joint decision-making process of the Mississippi Primary Health Care Association (MPHCA) and the MSDH Primary Care Development Program, making access to care available to many pregnant women and their infants. The Office of Rural Health (ORH) works closely with Primary Care Development to promote the recruitment and placement of providers in rural areas.

The MSDH, through its Office of Rural Health, administers the Medicare Rural Hospital Flexibility (FLEX) Grant, which funds the Critical Access Hospital program. This program is designed to foster the growth of collaborative rural health delivery systems across the continuum of care at the community level with appropriate external relationships for referral and support. This should result in improved access to care, economic performance and viability of rural hospitals, and ultimately, health status of the community. The Office of Rural Health contracts with the Mississippi Hospital Association to provide staff support and programmatic assistance for the FLEX program.

During the 1999 Legislative Session, House Bill 403 was passed that provided funding to the MSDH to increase access to preventive and primary care services for uninsured or medically indigent patients, and to create new services or augment existing services provided to uninsured or medically indigent patients. Services include, but are not limited to, primary care medical and preventive services, dental services, optometric services, in-house laboratory services, diagnostic services, pharmacy services, nutritional services, and social services. The MSDH serves as the conduit for this funding and contracts with Mississippi Qualified Health Centers to provide this increased access to care.

The MSDH HIV/AIDS Program maintains contractual agreements with a number of community agencies. The Jackson/Hinds Community Health Center provides AIDS education and information services to their clients in Hinds County and the Jackson public school system. Another agreement with the Aaron Henry Health Center in Clarksdale provides AIDS education and information to residents of Quitman, Tallahatchie, Tunica and Coahoma counties.

/2010/ The MSDH STD/HIV Office maintains sub-grants with ten community-based organizations and the University of Mississippi Medical Center (UMMC) to provide STD/HIV prevention, awareness, care and services. These activities are targeted to populations at highest demonstrated risk. People living with HIV and African-American men and women are the three top priority populations in Mississippi. The STD/HIV sub-grants address, among other issues, not becoming infected with STDs or HIV and the importance of routine HIV screening in general, particularly during pregnancy. Using federal Ryan White funds, the STD/HIV Office funds statewide medical case management for HIV-infected pregnant women (both distance consultations and direct care), as well as labor and delivery guidance and follow-up. The pediatric infectious disease sub-grant also pays for statewide medical case management of the perinatally-exposed infants until they are deemed HIV negative and for perinatally-infected infants until they are at least 18 years old. At this time they are transferred to the UMMC Adolescent and Adult Infectious services -- also funded to provide additional services through Ryan White pass-through money. MSDH also staffs eight District social work positions for case management of HIV patients. //2010//

The Family Planning Program maintains six contracts with community health centers and four contracts with universities and/or colleges for the provision of contraceptive supplies and educational materials. These contracts have been formulated with the Aaron Henry Health Center, Arenia Mallory Health Center, G.A. Carmichael Health Center, Northeast Mississippi Health Care, Inc., Southwest Health Agency for Rural People, Access Family Health Services, Jackson State University, Alcorn State University, Tougaloo College, and Coahoma Community

College.

/2010/ Family planning staff at the central office, district, and local health department levels provide continuous, informal collaboration and consultation to persons from the community including: other health care providers, teachers, students, patients, potential clients, and organizations. This includes providing and assisting with presentations, health fairs, training, etc. Family planning staff also participate with many different agencies, task forces, and coalitions in providing supportive services to various communities such: as letters of support, assistance with grant writing, service on various coalitions and community councils. //2010//

/2010/ Teen Pregnancy Prevention
The Jackson Medical Mall Pregnancy Prevention Project addresses teenage pregnancy prevention in two Jackson area schools, Lanier and Forrest Hill High Schools, through education, counseling and providing clinical services to address their family planning and reproductive health needs. Their efforts should assure timely intervention and ongoing support to students determined to be at risk, thereby reducing sexual behavior and subsequent pregnancies in many.
The G.A. Carmichael Family Health Center (GACFHC, a Community Health Center) Pregnancy Prevention Program addresses teenage pregnancy prevention through abstinence education in school-based clinics in two of the three counties served by GACFHC as well as teaching abstinence during certain school periods. Teens participate in Teen Summit held during the month of May (abstinence, pregnancy and disease prevention are discussed).
In addition to funding the two programs above, the MSDH Family Planning Program has established contracts with 12 Delegate Agency Providers which include: nine (9) Community Health Centers located in Public Health Districts I, II, III, IV, V, and VIII; two (2) Job Corps Centers in Public Health Districts I and V; and one (1) University Student Health Center in Public Health District V. These entities serve populations that typically do not visit and receive services from MSDH clinics and several have access to or are located in school based clinic settings (Aaron E. Henry Community Health Center in District I, Jackson Medical Mall Foundation Convenient Care Clinic, MS Job Corp Center, Batesville Job Corp Center) and service a larger population of teens. All provide contraceptive supplies, education, and counseling (supplies are provided by MSDH Family Planning Program funded through Title X). //2010//

The Breast and Cervical Cancer Screening and Early Detection program provides outreach activities and educational materials to promote awareness and prevention and contracts with community health centers, health departments, private providers, and hospitals to conduct screening services, diagnostic services, referrals and case management. The target populations for the program are uninsured, underinsured, and minority women. Women 50 years of age and older are the target group for mammography screening, and women 45 years and older are the target group for cervical cancer screening.

/2010/ The Breast and Cervical Cancer Program works closely with the Maternal Program to ensure that all women have access to quality care and also provides a Cancer Drug Program for women who are at or below 250% of the federal poverty level. //2010//

The Bureau of Immunization located in the Office of Communicable Disease, provides vaccine to private physicians and community health centers that are enrolled as Vaccine for Children providers.

The Office of WIC has a contractual relationship with 19 community health centers for the purpose of certification of women, infants, and children for provision of WIC food and/or formula through distribution centers located throughout the state.

Those community health centers that provide EPSDT services are also subject to the Division of Medicaid requirement for periodic lead screening. As the MSDH expands its statewide program of lead screening and follow-up to improve access to this service for potentially vulnerable populations, the cooperation of community health centers continues to be critical to its success in implementing community based interventions. The Mississippi State Department of Health received a CDC children lead prevention grant to implement lead prevention education and screening activities in targeted areas of the state.

Children's Medical Program (CMP)
CMP, the state CSHCN program, maintains an Advisory Council whose members include medical and other service providers and parents of CSHCN. Medical service providers of the Advisory Council include private physicians, a dentist, orthotics/prosthetics provider, and staff physicians of the University of Mississippi Medical Center, the only state funded medical teaching and tertiary care facility. A representative from the MSDH also serves on the State Developmental Disabilities Council. CMP partners with the Mississippi Disability Determination Service providing for the exchange of respective program eligibility criteria in cross referral of CSHCN for services.

The Children's Medical Program now maintains a Parent Advisory Committee composed of parents of CSHCN who are covered by the program. Parents provide input regarding the services that their children receive from the CSHCN program.

Maternal Death Review
In the past, the Mississippi State Medical Association's Committee on Maternal and Child Care reviewed all cases involving maternal deaths in the state. All maternal death certificates and matching birth certificates (if there was a live birth) or fetal death certificates were sent to the director of the Office of Women's Health. District and county health department staff were requested to gather information regarding prenatal care, labor and delivery, postpartum care and any other information surrounding the death. This information was used for both the in-house review and for the review by the Mississippi State Medical Association's Committee on Maternal and Child Care. The death certificates were revised in 1998 and a block added to check if the decedent had been pregnant within the last 90 days.

Nutrition Education
/2009/ The Nutrition Services program serves in an advisory capacity to programs and services. The primary focus is to encourage a healthier lifestyle, by means of improved nutrition and increased physical activity, throughout the agency and state. To reach this goal, two programs are being utilized to fight obesity. Bodyworks, a program for 9-13 year old girls and caregivers has resulted in over 170 trainers in the state completing the "Train-the-Trainer" course, preparing them to teach the 10-week course. Nutrition Services also has been instrumental in promoting changes in regulations for child care facilities. Some of the changes that have occurred are stricter meal guidelines, encouraging physical activity for children, and restricting the use of and products in vending. To also encourage healthier lifestyles in the preschool child and their parent, the department, along with Childcare Licensure, has launched a training program, "Color Me Healthy". This statewide program is for teachers in the preschool setting and targets incorporating food variety and physical activity using all five senses.
/2010/ "Color Me Healthy" training reached over 100 child care centers in 2008. Statewide classes for childcare providers on "Menu Writing 101"have reached over 150 centers. The classes help facilities incorporate healthier foods and preparation into the childcare facility. //2010//

We recognize the importance of eating fruits and vegetables for a healthier lifestyle. Nutrition Services provided pamphlets, recipes, and posters in the clinics for educating our clients on the use of and importance of including a variety of fruits and vegetables in the diet. The Fruits & Veggies-More Matters program has been incorporated in several Head Start programs to encourage the young child to try new foods. Nutrition Services also works with the Child Nutrition Program in the Department of Education to promote Fruits & Veggies-More Matters at school

events and education/health fairs.
/2010/ Our Fruits & Veggies-More Matters program reached over 11,000 individuals in 2008. //2010//

Nutrition Services also works with universities and colleges in precepting and training dietetic students. Dietetic students are assigned preceptors for community nutrition in the clinics. Students are assigned to educate clients through individual counseling, WIC certification, and group classes. The Department also hosts a "Genetics 101" conference for all students and professors annually. During the conference, students are introduced to the genetic and metabolic diseases that affect many of our children. Topics also include the processes to assist our children and their parents with dietary, emotional, and financial needs.

Education is a primary goal of Nutrition Services. Pamphlets, handouts, posters, cooking demonstrations, and food samplings are utilized to promote a healthier lifestyle. Community and professional education through media, lectures, "lunch-n-learn" series, workshops, and health fairs/screenings is encouraged throughout the agency and state. Resources are distributed to clinics and other providers when funding permits.
/2010/ The Department participated in screenings/health fairs that reached over 2000 individuals during 2008. //2010//

Mississippi, being declared one of the most obese states in the nation, is addressing this issue by working to implement the Body Works Program throughout the state. Body Works is a program designed to help parents and caregivers of adolescents improve family eating and exercise habits. Using a Toolkit, the program focuses on parents as role models and provides them the hands-on tools to make small, specific behavioral changes to prevent obesity and help families maintain a healthy weight. In addition to implementing the Body Works program, the MSDH will also utilize existing programs such as Blue Cross and Blue Shield of Mississippi and the Governor's Office "Let's Go Walkin' Mississippi" Program, the Association of State and Territorial Public Health Nutrition Directors (ASTPHND), "Blueprint for Nutrition and Physical Activity: Cornerstones of a Healthy Lifestyle" to improve the health status of all Mississippians, and the Division of Medicaid's "Roads to Good Health Guide Book" This and other statewide initiatives will be achieved by conducting education and outreach activities that encourage citizens to eat healthier, increase physical activity, participate in preventive health screenings that promote the utilization of community health care providers, and eliminate tobacco usage.
/2010/ MSDH is working closely with MS State Department of Education's Office of Healthy Schools in promoting healthier lifestyles for children and staff through assistance with Wellness Councils and educational efforts. //2010//

Social Work Services
Mississippi has a well established public health social work program whose major focus is promoting services for mothers, infants and children to age twenty-one and for children with special health care needs. MSDH employs a state director of public health social work who reports to the director of the office of Health Services, home to Mississippi's Title V program. The major characteristic of public health social work is an epidemiological approach to identifying social problems affecting the health status and social functioning of the MCH population. Emphasis is placed on intervention at the primary prevention level. Social workers assist patients in using the health care system. //2009//

Oral Health
/2009/ The MCH Block Grant provides salary support for a full-time dental director who determines oral health needs, develops policies, and coordinates programs and resources for population-based services. The FY 2005 MCH Needs Assessment showed that 70% of Mississippi's school-age children experienced tooth decay and two in five children have untreated dental decay. In 2006, a Governor's Oral Health Task Force approved a five-year (2006-2010) state oral health plan.

Community Water Fluoridation (Population-based Services)
Since July 2003, a private foundation has provided funding to equip and install water fluoridation programs. With this funding, 61 water systems have been recruited to begin fluoridation programs to benefit 290,646 people and 30 systems have been activated to serve 145,609 people. In June 2008, the proportion of MS population on fluoridated public water was slightly over 53%.

School-based Oral Health Programs (Population-based Services)
The MCHBG provides funding for a dental sealant program in nine counties in Public Health District III and two counties in District V. The FY 2005 MCH Needs Assessment showed that 12% of third-grade children had dental sealants in District III compared with 26% of children statewide. During the 2007-2008 school year, 1,620 dental sealants were placed on the permanent first molar teeth of 474 children in these counties. But tooth decay remains a serious problem in all 82 counties and additional MCHB funding is needed to expand the program. In FY 2007, a CDC-funded weekly school fluoride mouth rinse program served about 26,746 children in grades 1 thru 5 who live in non-fluoridated areas. CDC-funding is also used to employ 5.5 FTE dental hygienists who provide oral health education, perform oral health screening, and obtain oral health surveillance data. In April 2007, the Mississippi State Board of Dental Examiners adopted a resolution to permit the hygienists in the employ of the Board of Health to apply preventive fluoride varnish as part of oral health screening and education. During the 2007-2008 school year, we provided fluoride varnish to children ages 3 to 5 in a sample of 150 classrooms that participated in an oral health survey at 22 Head Start programs.

Oral Health Assessment in WIC Certification (Enabling Services)
Two oral health questions were included in the agency's WIC Certification to identify source of dental care and to identify pregnant women with symptoms of an oral infection. Data from 26,672 women showed that a higher proportion of blacks (58.8%) reported no source of dental care compared to whites (38.1%) who utilized the WIC service.

Children's Medical Program Dental Corrections (Direct Health Care)
Children diagnosed with cleft lip and/or palate or a craniofacial syndrome are eligible for coverage of procedures involving the oral cavity and related affected structures through the Children's Medical Program. In 2003, there were 381 CMP patients with the primary diagnosis of cleft lip/palate.

MSDH Mobile Dental Clinic (Direct Health Care)
In January 2007, the Sullivan-Schein Corporation donated a 51-foot mobile-dental-clinic equipped with two dental operatories, digital radiography, and electronic records for use to provide direct health care services. In February 2008, we collaborated with the University of Mississippi School of Dentistry to provide free dental care to about 50 people in the City of Clarksdale in the MS Delta. We seek additional funding to use this state-of-the-art mobile clinic to provide dental services in rural underserved communities. //2009//

Rural Health Program
The MCH program works collaboratively with the Office of Rural Health (ORH) in resolving access to care issues. This program is administered by the MSDH Office of Health Policy and Planning. This program has been funded through a Federal Office of Rural Health Policy grant since August, 1991. There are four mandated functions under the grant: (1) to establish and maintain a clearinghouse of rural health issues, trends, and innovative approaches to health care delivery in rural areas; (2) to coordinate activities carried out in the state that relate to rural health care in order to avoid redundancy; (3) to identify federal and state programs for rural health and provide technical assistance to public or nonprofit entities regarding participation in the programs and; (4) an option to provide technical assistance to rural hospitals and communities on recruitment and retention of health care professionals.

The Centers for Disease Control and Prevention and Health Resources and Services Administration provide funding for most services implemented through Health Services. Health

Services houses the MCH and CSHCN programs and is reliant on federal funds. Less than 2% of total funding to Health Services is provided by the State of Mississippi. Therefore, many MCH programs funded through Title V work in cooperation with national resources such as CDC and other HRSA/MCHB programs. Program staff are constantly in touch with project directors at the national level to ensure that needed services are provided to the MCH population.

F. Health Systems Capacity Indicators

Introduction

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	286.6	305.0	60.6	46.7	40.3
Numerator	5869	6246	1021	871	468
Denominator	204815	204815	168525	186390	116219
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008

Notes -2008

This is provisional data. As of 2-24.09, hospitals representing 53% of acute beds in MS have reported data. Due to significant geographic variations in asthma hospitalizations, the data from hospitals that have not reported as of the 2-24-09 estimate may significantly change the rate. 2008 Mississippi population estimates for children ages 0-4 will not be available until May or June 2009. Therefore, the 2008 provisional estimate uses the 2007 population in the denominator. The denominator used to calculate the rate is adjusted to account for the missing data due to non-reporting hospitals. The estimated denominator is calculated based on the percentage of hospital beds in the state accounted for in the reported data. Hospitals reporting data used in this calculation include 53% of all acute hospital beds in MS. Therefore, the 0-4 population estimate was adjusted by 53% (219,282 x 0.53=116,219).

Notes - 2007

The denominator used to calculate this rate is adjusted from the actual 2007 statewide 0-4 population estimate (219,282) to account for missing data due to non-reporting hospitals. The estimated denominator is calculated based on the percentage of hospital beds in the state accounted for in the reported data. As of June 11, 2008, hospitals reporting data used in this calculation account for 72% of all acute hospital beds in Mississippi. Therefore, the 0-4 population estimate was adjusted by 72% (219,282*.72=157883).

This rate may appear significantly different than estimates in prior years. Prior estimates were based on data from the tri-county Jackson metropolitan area only. The MSDH's asthma surveillance system has since expanded to collect statewide data. Due to incomplete data collection as of June 11, 2008, the denominator is adjusted by hospital bed coverage, as described in #1, to increase the validity of the estimate.

This is provisional data. Due to significant geographic variations in asthma hospitalizations, the

data from hospitals that have not reported as of the June 11, 2008 estimate may significantly change the rate.

2003 through 2006 rates were estimated based on 2003 provisional data for three Mississippi counties (Hinds, Rankin, and Madison). This data included emergency department and outpatient visits in addition to inpatient hospitalizations, and the population denominators were estimated. The rates reported for 2003 through 2006 are inflated due to these errors. As of 2007 these errors have been corrected. Data for 63 of the 82 Mississippi counties have been collected and analyzed using actual population denominators adjusted to reflect the population accounted for by the data. The 2007 provisional rate reflects the updated data collection and analysis procedures. The 2003 through 2006 rates for the 63 counties using the corrected collection and analysis procedures are as follows:

2003: 52.4 per 10,000 (981/187174)

2004: 53.8 per 10,000 (951/208556)

2005: 50.89 per 10,000 (918/209511)

2006: 60.6 per 10,000 (1021/168525)*

*2006 is provisional due to ongoing data collection.

Notes - 2006
2003 through 2006 rates were estimated based on 2003 provisional data for three Mississippi counties (Hinds, Rankin, and Madison). These data included emergency department and outpatient visits in addition to inpatient hospitalizations, and the population denominators were estimated. The rates reported for 2003 through 2006 are inflated due to these errors. As of 2007 these errors have been corrected. Data for 63 of the 82 Mississippi counties have been collected and analyzed using actual population denominators adjusted to reflect the population accounted for by the data. The 2007 provisional rate reflects the updated data collection and analysis procedures. The 2003 through 2006 rates for the 63 counties using the corrected collection and analysis procedures are as follows:

2003: 52.4 per 10,000 (981/187174)

2004: 53.8 per 10,000 (951/208556)

2005: 50.89 per 10,000 (918/209511)

2006: 60.6 per 10,000 (1021/168525)*

*2006 is provisional due to ongoing data collection.

Narrative:
The Mississippi State Department of Health has completed a five-year State Asthma Plan and established nine regional asthma coalitions and an Asthma Coalition of Mississippi. Mississippi

continues to enhance its asthma surveillance system, and has recently completed a five-year surveillance report.

2001-2004 indicator data were computed per 100,000 children; however, the Centers for Disease Control and Prevention (CDC) and other state asthma programs compute the hospitalization rate per 10,000. 2006 and 2007 estimates are provisional due to ongoing data collection.

Asthma is not a reportable disease in Mississippi, however the Asthma Program, funded through the CDC, is working with individual hospitals to obtain hospital discharge data on a regular basis. Currently, the Asthma Program is receiving data from over 80% of Mississippi hospitals.

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	68.6	71.4	66.9	77.7	90.0
Numerator	54829	28286	54356	53655	68037
Denominator	79869	39618	81284	69077	75599
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
Data provided by State of Mississippi, Division of Medicaid, April 2009

Notes - 2007
Both numerator and denominator represent unduplicated totals.

Narrative:
According to the latest data (CY 2007) from the Mississippi Division of Medicaid, of the 69,077 Medicaid enrollees whose age is less than one, 77.7% (53655) received a screening service. These data reflect the activities of MSDH clinics, FQHCs, and private providers. MSDH continues to work with Medicaid and other advocacy groups to encourage preventive screenings at every opportunity.

There continues to be a need for data linkage with the Mississippi Division of Medicaid for the purposes of reporting accurate data in a timely manner and monitoring increases and decreases in utilization of Medicaid services that impact the programs of the Mississippi State Department of Health. The State Systems Development Initiative (SSDI) grant is being used to promote data linkage between the Mississippi State Department of Health and the Mississippi Division of Medicaid.

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	76.3	76.3	81.1	88.5	100.0
Numerator	546	546	60	23	10
Denominator	716	716	74	26	10
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2007
SCHIP data reported by Blue Cross Blue Shield of Mississippi. HEDIS criteria requires that the denominator be limited to children turning 15 months old during the measurement year and having been continuously enrolled from 31 days of age, thus there was a small number of MS CHIP children who met this criteria.

Notes - 2006
According to data from the Division of Medicaid, the numbers reported in this measure are "Well child visits during the first 15 months of life", as reported on the CHIP Annual Report FFY 2006. A periodic screening is for Medicaid beneficiaries only, and the majority of Medicaid enrolled infants under one (1) year receive screenings as a result of the EPSDT program.

Narrative:
According to CY 2006 data from the Mississippi Division of Medicaid, 81% of the children enrolled in SCHIP who were less than one year of age at some point during the year, had a visit to a health care professional (physician, nurse practitioner, etc.) before one year of age.

There continues to be a need for data linkage with the Mississippi Division of Medicaid, coordinator for the State Children's Health Insurance Program (SCHIP), for the purposes of reporting accurate data in a timely manner and monitoring increases and decreases in utilization of Medicaid services that impact the programs of the Mississippi State Department of Health. The State Systems Development Initiative (SSDI) grant is being used to promote data linkage between the Mississippi State Department of Health and the Mississippi Division of Medicaid.

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	84.1	82.2	83.6	84.7	84.8
Numerator	35831	34643	38337	39201	39210
Denominator	42595	42120	45833	46261	46261
Check this box if you cannot report the numerator because					

1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Narrative:
According to 2007 provisional data 84.4 percent of women (15 through 44) with a live birth during the reporting year had observed expected prenatal visits greater than or equal to 80 percent of the Kotelchuck Index.

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	96.7	94.7	81.3	80.5	84.3
Numerator	382511	347715	327214	317487	327772
Denominator	395621	367091	402241	394306	388679
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
Data provided by State of Mississipp, Division of Medicaid, April 8, 2009

Narrative:
Data from the Mississippi Division of Medicaid revealed that during CY 2007, there were 394,306 children 1 to 21 years of age who were potentially eligible for Medicaid. Of that number, 317,487 (80.5%) received a service paid by the Medicaid Program.

There continues to be a need for data linkage with the Mississippi Division of Medicaid for the purposes of reporting accurate data in a timely manner and monitoring increases and decreases in utilization of Medicaid services that impact the programs of the Mississippi State Department of Health. The State Systems Development Initiative (SSDI) grant is being used to promote data linkage between the Mississippi State Department of Health and The Mississippi Division of Medicaid.

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**

Annual Indicator	43.6	88.4	37.9	46.0	51.5
Numerator	36421	69233	34715	36073	39940
Denominator	83629	78320	91548	78378	77531
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
Data provided by State of Mississippi, Division of Medicaid, April 8, 2009

Notes - 2006
According to data from the Division of Medicaid, the numerator is based on paid claims to dental providers who performed a dental service. The number does not include oral health screening services.

Narrative:
According to CY 2007 data from the Division of Medicaid, 78,378 children age 6 through 9 were eligible for EPSDT services. Of that number, 46 percent (36,073) received dental services.

There continues to be a need for data linkage with the Mississippi Division of Medicaid for the purposes of reporting accurate data in a timely manner and monitoring increases and decreases in utilization of Medicaid services that impact the programs of the Mississippi State Department of Health. The State Systems Development Initiative (SSDI) grant is being used to promote data linkage between the Mississippi State Department of Health and the Mississippi Division of Medicaid.

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	100.0	0.7	3.6	3.4	3.9
Numerator	18784	127	688	662	748
Denominator	18784	19084	19250	19328	19328
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2006

Data reported during 2005 and 2006, unlike previously reported data, is based on the actual percent of state SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program. Previous yearly percentages reported were based on the percentage of SSI beneficiaries less than 16 having access to CSHCN program services due to a collaborative effort between Medicaid, the Social Security Administration, and other third party payors to ensure access to needed services for children with special health care needs. It is important to note that the state's CSHCN program does not provide direct services for children with emotional, behavioral, and mental health needs. However, children with needs for these services are referred to the State's Mental Health network of providers.

Narrative:
The Children's Medical Program (CMP) staff maintains an ongoing relationship with the Social Security Administration and the State Disability Determination Services to facilitate the referral process to CMP for children and families potentially eligible for the program. The CMP collaborates with Medicaid, Social Security Administration and other third party payors to ensure access to needed services for children with special health care needs.

Each SSI beneficary is made aware of CMP, eligilibility criteria, and covered services. All beneficaries are encouraged to apply for CMP services. However, all SSI beneficaries may not directly receive rehabilitative services through the CSHCN program due to differences in eligibility criteria for program enrollment.

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of low birth weight (< 2,500 grams)	2007	other	65	35	12.3

Notes - 2010
No linked data file exists at this time. Data calculations are estimates based on a combination of sources which include Vital Statistics and Medicaid sources.

There continues to be a need for data linkage with the Mississippi Division of Medicaid for the purpose of reporting accurate data in a timely manner and monitoring changes in the utilization of Medicaid services which impact the programs of the Mississippi State Department of Health. The State Systems Development Initiative (SSDI) grant is being used to promote data linkage between the two agencies.

Narrative:
There continues to be a need for data linkage with the Mississippi Division of Medicaid for the purposes of reporting accurate data in a timely manner and monitoring increases and decreases in utilization of Medicaid services that impact the programs of the Mississippi State Department of Health. The State Systems Development Initiative (SSDI) grant is being used to promote data linkage between the Mississippi State Department of Health and The Mississippi Division of Medicaid.

In this table, the MEDICAID box represents the percentage of the population described in the Health Systems Capacity Indicator that was on Medicaid. The NON-MEDICAID box represents all others. The ALL box represents the percentage of the population described in the Health Systems Capacity Indicator among the entire number of live births.

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Infant deaths per 1,000 live births	2007	other	6.4	3.7	10.1

Notes - 2010
No linked data file exists at this time. Data calculations are estimates based on a combination of sources which include Vital Statistics and Medicaid sources.

There continues to be a need for data linkage with the Mississippi Division of Medicaid for the purpose of reporting accurate data in a timely manner and monitoring changes in the utilization of Medicaid services which impact the programs of the Mississippi State Department of Health. The State Systems Development Initiative (SSDI) grant is being used to promote data linkage between the two agencies.

Narrative:
There continues to be a need for data linkage with the Mississippi Division of Medicaid for the purposes of reporting accurate data in a timely manner and monitoring increases and decreases in utilization of Medicaid services that impact the programs of the Mississippi State Department of Health. The State Systems Development Initiative (SSDI) grant is being used to promote data linkage between the Mississippi State Department of Health and The Mississippi Division of Medicaid.

In this table, the MEDICAID box represents the percentage of the population described in the Health Systems Capacity Indicator that was on Medicaid. The NON-MEDICAID box represents all others. The ALL box represents the percentage of the population described in the Health Systems Capacity Indicator among the entire number of live births.

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**

MCH populations in the State					
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2007	other	49	51	81.1

Notes - 2010
No linked data file exists at this time. Data calculations are estimates based on a combination of sources which include Vital Statistics and Medicaid sources.

There continues to be a need for data linkage with the Mississippi Division of Medicaid for the purpose of reporting accurate data in a timely manner and monitoring changes in the utilization of Medicaid services which impact the programs of the Mississippi State Department of Health. The State Systems Development Initiative (SSDI) grant is being used to promote data linkage between the two agencies.

Narrative:
There continues to be a need for data linkage with the Mississippi Division of Medicaid for the purposes of reporting accurate data in a timely manner and monitoring increases and decreases in utilization of Medicaid services that impact the programs of the Mississippi State Department of Health. The State Systems Development Initiative (SSDI) grant is being used to promote data linkage between the Mississippi State Department of Health and The Mississippi Division of Medicaid.

In this table, the MEDICAID box represents the percentage of the population described in the Health Systems Capacity Indicator that was on Medicaid. The NON-MEDICAID box represents all others. The ALL box represents the percentage of the population described in the Health Systems Capacity Indicator among the entire number of pregnant women.

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2007	other	51	49	84.7

Notes - 2010
No linked data file exists at this time. Data calculations are estimates based on a combination of sources which include Vital Statistics and Medicaid sources.

There continues to be a need for data linkage with the Mississippi Division of Medicaid for the purpose of reporting accurate data in a timely manner and monitoring changes in the utilization of Medicaid services which impact the programs of the Mississippi State Department of Health. The State Systems Development Initiative (SSDI) grant is being used to promote data linkage between the two agencies.

Narrative:
There continues to be a need for data linkage with the Mississippi Division of Medicaid for the purposes of reporting accurate data in a timely manner and monitoring increases and decreases in utilization of Medicaid services that impact the programs of the Mississippi State Department of Health. The State Systems Development Initiative (SSDI) grant is being used to promote data linkage between the Mississippi State Department of Health and The Mississippi Division of Medicaid.

In this table, the MEDICAID box represents the percentage of the population described in the Health Systems Capacity Indicator that was on Medicaid. The NON-MEDICAID box represents all others. The ALL box represents the percentage of the population described in the Health Systems Capacity Indicator among the entire number of pregnant women.

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Infants (0 to 1)	2008	185
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Infants (0 to 1)	2008	200

Narrative:
There continues to be a need for data linkage with the Mississippi Division of Medicaid for the purposes of reporting accurate data in a timely manner and monitoring increases and decreases in utilization of Medicaid services that impact the programs of the Mississippi State Department of Health. The State Systems Development Initiative (SSDI) grant is being used to promote data linkage between the Mississippi State Department of Health and The Mississippi Division of Medicaid.

In this table, the MEDICAID box represents the percentage of the population described in the Health Systems Capacity Indicator that was on Medicaid. The NON-MEDICAID box represents all others. The ALL box represents the percentage of the population described in the Health Systems Capacity Indicator among all infants (age 0 to 1).

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06	**YEAR**	**PERCENT OF**

The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.		**POVERTY LEVEL Medicaid**
Medicaid Children (Age range 1 to 5) (Age range 6 to 19) (Age range to)	2008	 133 100
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Medicaid Children (Age range 1 to 5) (Age range 6 to 19) (Age range to)	2008	 200 200

Narrative:
There continues to be a need for data linkage with the Mississippi Division of Medicaid for the purposes of reporting accurate data in a timely manner and monitoring increases and decreases in utilization of Medicaid services that impact the programs of the Mississippi State Department of Health. The State Systems Development Initiative (SSDI) grant is being used to promote data linkage between the Mississippi State Department of Health and The Mississippi Division of Medicaid.

In this table, the MEDICAID box represents the percentage of the population described in the Health Systems Capacity Indicator that was on Medicaid. The NON-MEDICAID box represents all others. The ALL box represents the percentage of the population described in the Health Systems Capacity Indicator among all children (age 1 to 19).

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Pregnant Women	2008	185
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Pregnant Women	2008	

Notes - 2010
According to guidance provided by the Division of Medicaid, the percent of poverty level for eligibility of pregnant women in the SCHIP program field should be left blank to indicate a lack of applicability since only pregnant females who are minors are eligible and the majority of them are switched to the Medicaid program once the pregnancy is detected. If "pregnant women" is defined as women of any age, then this field is not applicable.

Narrative:

There continues to be a need for data linkage with the Mississippi Division of Medicaid for the purposes of reporting accurate data in a timely manner and monitoring increases and decreases in utilization of Medicaid services that impact the programs of the Mississippi State Department of Health. The State Systems Development Initiative (SSDI) grant is being used to promote data linkage between the Mississippi State Department of Health and The Mississippi Division of Medicaid.

In this table, the MEDICAID box represents the percentage of the population described in the Health Systems Capacity Indicator that was on Medicaid. The NON-MEDICAID box represents all others. The ALL box represents the percentage of the population described in the Health Systems Capacity Indicator among the entire number of pregnant women.

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	**Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)**	**Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)**
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	2	No
Annual linkage of birth certificates and WIC eligibility files	2	Yes
Annual linkage of birth certificates and newborn screening files	3	Yes
REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	2	Yes
Annual birth defects surveillance system	3	Yes
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

Notes - 2010

Narrative:

Although a well coordinated network of services is being provided on a statewide basis by the MSDH, there is a need for data linkage to improve and/or target services to the more vulnerable populations in Mississippi. Useful data to better serve the MCH population are being captured through surveillance systems and/or surveys such as PRAMS, Youth Tobacco and the Youth Risk Behavior Surveys, but other data linkages are needed for analyses and development of innovative ways to address health care disparities in Mississippi. The MSDH Office of Health Data and Research plans to continue its work with the Department of Vital Records to establish data linkage between birth and infant death records and WIC eligibility; data linkage between birth and infant death records and Medicaid files; and to conduct statewide need assessments as needed. Progress in accomplishing these objective has been made, but challenges exist in staffing and compatible data systems. Additional challenges also exist that are due to the MSDH's quest to reconstruct the agency's current data collection systems to establish a more centralized integrated data system for improved data analysis. The establishment of an improved data collection system will be used to aide MSDH in the sharing of quality data to assist its partners and other health care providers throughout the state to create and develop innovative ways to better respond to the health concerns of the citizens of Mississippi.

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	**Does your state participate in the YRBS survey? (Select 1 - 3)**	**Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)**
Youth Risk Behavior Survey (YRBS)	3	Yes

Notes - 2010

Narrative:
Although the Mississippi State Department of Health does have direct access to the state YRBS database for analysis, the need exists for data linkage among the various data sources within and available to the MSDH. Useful data to better serve the MCH population are being captured through surveillance systems and/or surveys such as PRAMS, Youth Tobacco and the YRBS, but other data linkages are needed for analyses and development of innovative ways to address health care disparities in Mississippi.

IV. Priorities, Performance and Program Activities

A. Background and Overview

In an effort to carry out the core functions of public health, the MSDH relies on the work of public health team members across the state to assist every community in the state to achieve the best possible health status for its citizens. The MSDH accomplishes this through the agency's goals of:

(1) Assessing health status indicators of the state's population to document each community's health needs and conduct epidemiological and other studies of specific health problems; (2) Developing, promoting, and supporting public policy and strategies that protect the state's citizens from unsanitary conditions related to the environment and that emphasize healthy lifestyles and the prevention of morbidity and mortality associated with disease and illness; and (3) Assuring access to essential health services.

The MSDH's Health Services (HS) department, through the Office of Women's Health and the Office of Child/Adolescent Health Services, administers programs that provide services for the three major populations targeted by the MCH Block Grant: women and infants, children and adolescents, and children with special health care needs (CSHCN). Clinical and support services are provided to the target populations through local county health departments and speciality clinics. Services include prenatal and postnatal care, case management for high risk pregnant and postpartum women and infants, well child and sick child care, as well as restorative services for CSHCN. This network allows the MSDH to address the needs of children and families, especially those with low incomes, in a family-centered, community-based and coordinated manner that ensures access and availability of quality health care.

The MSDH Child Health and Prenatal programs serve all women, infants, and children but target services to women, infants, and children at or below 185 percent of poverty. Services are preventive in nature; however, treatment is often included for those whose need is greatest. Using a multi-disciplinary team approach, including medical, nursing, nutrition and social work, the Child Health Program provides childhood immunizations, well child assessments, limited sick child care, and tracking of infants and other high risk children. Services provided are basically preventive and designed for early identification of health concerns. Case management services are provided to high risk pregnant and postpartum women and infants by nurses, social workers and nutritionists. Services are provided in clinics and in the clients' homes.

In areas where the MSDH is not the primary provider of care, the MSDH contracts and/or collaborates with private providers to care for the MCH and CSHCN population. Some of these providers conduct regular and/or screening clinics in health department facilities. Others are contracted for consultation and referrals. The MSDH provides support services such as case management, nutrition and psychosocial counseling, education and nursing.

In some areas of the state, prenatal patients are seen in health department clinics until delivery and then return to MSDH for postpartum and family planning services after delivery. High risk patients are sometimes co-managed by the health department and the private provider.

In other parts of the state, the health department has contractual agreements with private providers whereby the MSDH manages the patient until a certain stage of gestation and then transfers the patient to the private provider for the remainder of her care. There are several areas of the state where, when a patient's pregnancy is confirmed, she goes immediately into the private sector or to a community health center or rural health clinic for care.

/2009/ The number of maternity clients seeking prenatal care at county health departments has started to increase within the past few years. During FY 2005, a total of 7,997 clients received prenatal care at county health departments. By FY 2007, the number of clients receiving

maternity services from county health departments had risen to a total of 8,356. During CY 2007, 18 percent of the women who gave birth in Mississippi received their prenatal care in county health departments. //2009//

The MSDH, in administering the Title V programs, has taken steps to integrate the private medical community into the system through contractual arrangements whereby local physicians provide limited clinical coverage at local health departments. These physicians enhance the continuum of care by becoming the client's provider of after-hours and weekend care when necessary and many times provide a medical home for families as the family's economic status improves.

B. State Priorities

STATE PRIORITIES

Mississippi's health priorities from the 2006 Needs Assessment are enumerated below:

1. Increase EPSDT/preventive health services for children on Medicaid and SCHIP.

2. Decrease smoking among pregnant women.

3. Decrease cigarette smoking among sixth through twelfth graders.

4. Reduce repeat teen pregnancies for adolescents less than 18 years old.

5. Address child/adolescent obesity/overweight issues.

6. Increase oral health care and preventive services for children.

7. Reduce child/adolescent unintentional injuries.

8. Decrease unhealthy behaviors, specifically alcohol and drug use and risky sexual behavior, for teenagers sixth through twelfth grades.

9. Maintain case management follow-up services for children with genetic disorders identified through MSDH newborn screening.

10. Continue to improve and maintain developed data collection capacity for Title V population

These state priorities were derived from the needs assessment process in 2004 and 2005. Priorities were determined based on the needs of the MCH population in relation to current MCH Block Grant state and national measures. The priorities are designed to complement national performance measures without duplicating efforts that are currently being used to address performance measures. Each priority, however, does relate in some way to the state and national performance measures as well as Healthy People 2010 goals. Eight state performance measures were derived from these priorities and are detailed on subsequent forms in this grant application/report. Below are summaries of each priority and why it was chosen.

EPSDT/Preventive Health Services: This priority was carried over from the previous cycle and enhanced. Little more than one-half of Medicaid eligibles receive preventive health screenings. One may reasonably assume a comparable percentage for SCHIP eligibles. Therefore, SCHIP was added to this priority and to the state performance measure that corresponds with this

priority.

Smoking Among Pregnant Women: During the previous cycle, smoking among pregnant teenagers was selected as a priority to focus efforts on a specific age group of pregnant women. When revisited, it was agreed that this priority should be expanded to include all pregnant women. As data reflect, women who smoke during pregnancy are more likely to be low socioeconomic status, minorities, and deemed high risk. Smoking in itself makes pregnant women high risk due to the effects of smoking on unborn babies. In Mississippi, approximately 25% of pregnant women smoke. This statistic makes the size, seriousness, and scope of the issue appropriate for selection as a top priority.

Cigarette Smoking Among Sixth through Twelfth Graders: Cigarette smoking among youth continues to be a public health problem in Mississippi. Progress has been made to address youth smoking in Mississippi. However, according to 2007 YRBSS, the percent of children who report having smoked in the last 30 days or having ever smoked is well above the national average. Therefore, this priority was selected to remain in the top ten priorities. In the past, due to only having weighted data for ninth through twelfth graders, sixth through eighth graders were not included. Due to improved data resources, the priority will be enhanced to include sixth through twelfth graders, increasing the global scope of the priority.

Repeat Teen Pregnancy: Teen pregnancy remains a problem in Mississippi. Currently, over 40 per 1,000 births are to adolescent mothers. The rate of repeat teen pregnancies continues to be of special concern. Since a national performance measure to address teen pregnancy for 15-17 year olds exists, the workgroup desired to address the issue of repeat teen pregnancy. Repeat teen pregnancies remain around 140 or more per 1,000 live births to teens. This statistic accounts for approximately 25% of all teen births, above the national average according to Child Trends- Research Brief (2007). Although it has declined in recent years, the rate is still a major concern due to implications for repeat teenage births. Adolescent mothers are at risk for LBW and preterm births, and a host of other health problems. This priority will remain in the top priorities for 2006-2010 so that more can be done to address this issue.

The Mississippi State Department of Health Office of Child and Adolescent Health continues to assist Mississippi Department of Human Services Abstinence Education Program with the development and planning of the annual "Just Wait" Teen Abstinence Summit. This year's abstinence educational awareness summit attracted approximately 6,000 middle and high school students from across the Mississippi.

Childhood Obesity: Overweight or obese children, poor nutrition and physical inactivity have drawn public attention in recent years. Mississippi's children are becoming increasingly overweight, as is the adult population. Mississippi ranks among the most obese states in the U.S. According to 2007 YRBSS data, over 17.9% of youth self report as being overweight and another 17.9% as at risk for becoming overweight. With physical education at an all time low and education funding woes, little seems to be in progress to influence this growing problem. Childhood obesity must be made priority so that multi-agency combined efforts may collaborate to eliminate child obesity.

Unintentional Injuries and Violence in Children: Mississippi holds one of the highest rates of childhood unintentional injuries and deaths. Most childhood deaths and injuries occur before age 14 with the highest risk ages being 0-5 years. Adolescent injuries comprise the second highest risk group. According to CY 2006 data from MSDH Vital Statistics shows that 32.1 per 100,000 deaths will occur in children between ages one and 14 years. According to the 2008 Kids Count Data Book, 69 per 100,000 teenagers aged 15-19 die as a result of homicide, suicide, and accidents. This statistic is well above the national average of 50 per 100,000 deaths. These statistics support selection of this issue to be addressed during the next cycle.

Using technical assistance, networking initiatives and partnerships to plan programs and

coordinate efforts, the Mississippi State Department of Health works with Mississippi Office of Public Safety to reduce the incidence of alcohol-related fatal and injury traffic crashes among the adolescent driver population. Teens on the Move, a statewide awareness and educational youth conference is planned and implemented by Mississippi Office of Public Safety. The program seeks to reduce needless deaths and injuries associated with motor vehicle crashes; promotes healthy lifestyles among adolescents; encourages student leadership in alcohol and drug prevention and highway safety; provides a platform for motivating schools to continue providing guidance in highway safety programs and alcohol and drug prevention. The conference targets students in grades 5 to 12 who participate in Students Against Destructive Decisions (SADD) or other clubs choosing to be alcohol and drug-free and respect highway safety laws. SADD provides students with intervention and prevention tools to deal with issues of underage drinking, drunk driving, drug abuse and other destructive decisions in Mississippi.

/2010/ In 2007, data from MSDH Vital Statistics indicated that injury-related fatalities were the leading cause of death for children ages 1 to 18 years, and the fourth leading cause of death for infants. Motor vehicle crashes continue to account for most injury-related deaths, typically due to misuse or non-use of child occupant restraints and seat belt systems. The rate of motor vehicle-related fatalities in children ages 1- 18 has increased by more than 6% over the last five years, according to MSDH Vital Statistics data. Therefore, the Injury and Violence Prevention Program has continued to target motor vehicle safety and promote correct child occupant protection. In 2008 alone, 5,968 child restraints were distributed across the state of Mississippi. Expansion of the program has involved collaboration with the Pregnancy High Risk Management program, where one district has been selected to pilot the Safety Seat Incentive program. Through this collaboration, the Injury and Violence Program has certified 15 PHRM staff from that district as Child Passenger Safety Technicians and has provided 150 convertible car seats to use as motivational rewards for patient attendance to clinic appointments. Expected outcomes include specific targeting of a high-risk, low-income population and increased compliance with appointment scheduling (which should result in higher revenue for the PHRM program, increased effectiveness of the program, and decreased consumption of case manager time due to appointment rescheduling). Expansion efforts such as this continue to be made in all areas of injury prevention.

In 2007, homicide and suicide, along with accidents, accounted for the top three causes of deaths for teenagers aged 15 to 19 years. Therefore, intentional youth violence continues to be a desired target of educational programming and intervention implementation. The Injury and Violence Prevention Program has partnered with the Mississippi Department of Mental Health to implement school-based suicide prevention efforts in areas of the state with the highest frequency of teen suicides. //2010//

Unhealthy Behaviors in Adolescents Sixth through Twelfth Grades: The Youth Risk Behavior Surveillance System shows that the state's data on teenagers in Mississippi consistently ranks above national averages for unhealthy behaviors. As an MCH program, the MSDH will address unhealthy behaviors in hopes of lowering those averages to meet or fall below national averages in order to improve health status. STD rates for teenage males, drug and alcohol use, and injuries are a public health problem. Through the needs assessment, Mississippi has chosen to address unhealthy behaviors through other state performance measures, such as repeat teen pregnancy, obesity, and cigarette smoking.

Case Management Follow-up for Children with Genetic Disorders: The state leads in newborn screening and identification of genetic disorders and birth defects. Mississippi screens for over 40 genetic disorders and MSDH follows identified cases through case management services. During the past five years, the MSDH worked diligently to capture all families who had a newborn with a genetic disorder and offered case management, education, and support. Case management efforts are reaching close to 100% of families having a newborn identified through the newborn screening program. This priority will remain a top priority to support continued success within the

program.

Data Collection Capacity: During the 2000 needs assessment cycle, a separate entity for data collection and capacity was a fairly new concept. A CDC assignee had been struggling to develop MCH data capacity. The workgroup determined the best way to address such an issue was to make it a top priority. Over the next five years a great amount of growth and strengthening occurred. Much has been done to address the issue of data capacity and infrastructure. However, data collection capacity should remain a top priority for this needs assessment cycle, but not as a state performance measure.

Summary: The Title V MCH Needs Assessment process consisted of several methodological principals to ensure the ongoing nature of the process and incorporate results and activities with other portions of the grant application and annual report. National and state performance measures were examined. Overall MCH health status was considered. Capacity indicators were used to develop the state's top ten priorities and develop new state performance measures based on needs assessment evidence. Steps involved the collaboration of a workgroup, conducting special analyses, analyzing health status and existing data, identifying current activities to address needs, and finally, assigning top priorities along with developing with a plan to address the priorities and monitor progress over the next five years.

To assess communities and MCH needs statewide, similar qualitative and quantitative methods were used. Surveys developed by ad hoc committees were based on surveys used during the 2000 Needs Assessment. The committees essentially built upon strengths of existing surveys and enhanced questions to meet the changing Mississippi climate. Other similarities consisted of the convening of the needs assessment workgroup and conferences to present data findings. The state's capacity to meet the needs identified by the 2005 needs assessment is adequate and provides room for growth and further capacity development.

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	99.6	99.7	100	100	100
Annual Indicator	99.4	100.0	100.0	100.0	100.0
Numerator	41219	100	136	131	116
Denominator	41488	100	136	131	116
Data Source					MSDH
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	100	100	100	100	100

Notes - 2008
All 116 of the reported number of children with genetic disorders received case management follow-up services.

Notes - 2007
Denominator and numerator are based on the numbers of positive screens and the number receiving follow-up services.

Notes - 2006
Denominator and numerator are based on the numbers of positive screens and the number receiving follow-up services.

a. Last Year's Accomplishments
Last year during CY 2008, one hundred-sixteen (116) newborns were confirmed with a genetic disease/disorder through the newborn screening program. Follow-up, counseling and referral for medical evaluation and treatment were provided for 116 or (100%) of babies detected with a genetic disorder. This was accomplished through the support of the CSHCN Coordinators. The teams in the public health districts coordinate with county staff to follow up on presumptive positive screens. The coordination of newborn screening follow-up includes; facilitation, evaluation, diagnosis management, and education which are essential public health activities. These activities contribute to the success of this population-based screening program.
Program staff attended several conferences sponsored by The Southeastern Regional Genetics Group (SERGG) and The American Public Health Laboratory (APHL). The meetings engaged staff in discussions about policies and practices to improve newborn screening programs; identified barriers to families and; discussed strategies to enhance long-term care coordination of children with genetic conditions. Staff also provided trainings for Public Health staff on various genetic disease/disorders. The program shared outcome data on children during the bi-annual trainings (April & September) with the CSHCN Coordinators. The program collaborated with specialty providers to conduct several trainings for staff on the follow-up of disorders (e.g. Barts, Thalassemia and Metabolic). There were three regional in-service trainings (Grenada, Jackson and Hattiesburg) for hospital providers on newborn screening protocols from specimen collection and handling to receipt of reports. The program collaborated with the Health Service Data Unit on the development of a Data Management/Analysis Plan for the newborn screening program. The data manager conducted an analysis and reported on (2004-2007) data at several meetings during the year.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to provide screening of all births occurring in the state and follow-up on all inconclusive, abnormal, and presumptive positive results			X	
2. Provide family counseling and arrange for repeat screens for all babies with inconclusive and abnormal results, and arrange for diagnostic evaluations for all babies with presumptive positive results		X		
3. Identify all confirmed cases of genetic disorders detected through the screening process		X		
4. Assure that children diagnosed with genetic disorders have a local medical home and are under the care of a physician		X		
5. Continue to assist in coordinating the case management of affected children with local health departments and physicians		X		
6.				
7.				

8.				
9.				
10.				

b. Current Activities
The program's current activities include continued education on the importance of newborn screening to health care providers, parents, the public and public health staff.

c. Plan for the Coming Year
Mississippi's plan for the coming year is to continue screening newborns and provide immediate short-term follow-up, counseling and referrals to facilitate medical evaluation and treatment to families with infants born with genetic diseases/disorders. In addition to implementing activities necessary to maintain the percent of newborns screened and confirmed, staff will continue to educate health care providers and parents on the importance of timely screening and follow-up. The program will evaluate funding opportunities for the expansion of other genetic services. These include but are not limited to support groups for families of children with genetic conditions; identifying funds to increase education on genetic disease management for parents, staff and providers. The program will also collaborate with other child health programs to identify resources and expand the existing electronic resource manual developed by the Children's Medical Program.

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	47.5	50.5	53.5	56.5	62.5
Annual Indicator	41.5	41.5	41.5	60.4	60.4
Numerator	147	147	147	442	442
Denominator	354	354	354	732	732
Data Source					National CSHCN Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	63	63.5	64	64.5	64.5

Notes - 2008
Note 2008: Data only available from The National Survey of Children with Special Health Care Needs Chartbook 2005-2006 HRSA for Mississippi Children.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

During the enrollment process all applicants are requested to identify their medical home. If they indicate they do not have one, they are instructed on the need for a medical home. Then they are referred to a physician in their community.

a. Last Year's Accomplishments
Parents of CSHCN participating on the Children's Medical Program Advisory Committee provided program input along with physicians and other CMP professional and non-professional providers. A random satisfaction survey of 300 families was conducted. Most respondents expressed satisfaction with the services they received from CMP and shared suggestions concerning program improvement. The Children's Medical Program's parent consultant worked closely with the parent and youth advisory committees and served as an important link between the CMP and the committees. The Parent Advisory committee met two times during the year; The Youth Advisory committee met once every quarter during the year. Both committees met with CMP staff and other stakeholders to discuss program issues and family needs.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Maintain family participation through the program advisory committee		X		
2. Maintain CMP Parent Advisory Council		X		
3. Include patient and family subcommittee input in the MCH Block Grant Needs Assessment				X
4. Continue contractual agreements with community based organizations that serve CSHCN to provide support services for families				X
5. Utilize a Family Satisfaction Survey tool to obtain information from families regarding the services they receive				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities
CSHCN families continue to participate in program and policy development through their participation as members of the Children's Medical Program (CMP) Advisory Committees throughout the state. Interactive Video Training was provided to families statewide as a result of the Parent Advisory Committees input into CMP's plans for improving services to families. The Children's Medical Program in collaboration with the Parent Family to Family Health Information and Education Center (F2FC) Coordinator is developing a Family Peer Support Network. Focus groups are also being developed to determine family's preferences for additional family and parent support services. In collaboration with F2FC, efforts are being made to organize a stakeholder Advisory Committee comprised of parents, family members, youth and providers to develop and conduct training and provide input on the development of policies and procedures. The second of three random surveys of 300 families of Children with Special Health Care Needs will be conducted this spring.

c. Plan for the Coming Year
Mississippi's plan for the coming year relevant to this measure is to enhance, as well as continue to assure family participation in program policy activities in the State's CSHCN Program. CMP will continue to work to maintain family participation through the program advisory committee. A Stakeholder advisory committee will be organized with the University of Southern Mississippi Institute for Disability Studies. The Parent Consultant and Children with Special Health Care Needs Coordinator teams will continue work to establish regional family support groups.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	48.2	50.2	52.2	54.2	45.8
Annual Indicator	44.2	44.2	44.2	45.0	45.0
Numerator	312	312	312	340	340
Denominator	706	706	706	756	756
Data Source					National CSHCN Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	46.2	47	47.5	48.2	48.2

Notes - 2008
Note 2008: Data only available from The National Survey of Children with Special Health Care Needs Chartbook 2005-2006 HRSA for Mississippi Children.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

a. Last Year's Accomplishments
CMP assessed medical home status of all enrollees at the time of application processing, as well as, during visits at the specialty clinics. Ninety-four percent (94%) of the children enrolled in CMP have reported having a medical home. Fifty-one percent (51%) of children enrolled in CMP have reported having a dental home. The medical director for CMP conducted 4 presentations for various medical professionals on CMP and how it relates to the medical home concept.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Assess medical home status at all clinic encounters and make referrals as needed				X
2. Collaborate with primary care physician groups to increase the availability of medical homes				X
3. Continue to coordinate with the University Medical Center to provide care coordination				X
4. Develop CMP case management positions (as funds allow) to provide care coordination services				X
5. Utilize district CSHCN Coordinators to assist in care coordination at the community level				X
6. Continue to provide continuing education opportunities for primary care providers on topics related to CSHCN				X
7. Participate in training for primary care providers on the medical home concept of CSHCN (conferences, continuing education activities, etc.)				X
8.				
9.				
10.				

b. Current Activities

The Children's Medical Program (CMP) continues to assess medical home status of all enrollees at the time of application processing and during visits to specialty clinics. CMP continues to collaborate with Living Independence for Everyone of Mississippi (LIFE) to promote the importance of medical homes at transition clinics and conferences. Children's Medical Program and Family to Family Health Information and Education Center (F2FC) are in the process of providing educational training opportunities, developing and disseminating information for families and providers related to medical homes.

c. Plan for the Coming Year

The MSDH's Children's Medical Program (CMP) will continue to partner with the community based organization, LIFE, to implement transition activities. LIFE has several activities directly related to program efforts. CMP will continue to support the Family to Family Health Information and Education Center's efforts to provide educational training opportunities and develop and disseminate information for families and providers related to medical homes.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	57.7	60.7	63.7	66.7	62.5
Annual Indicator	51.7	51.7	51.7	58.8	58.8
Numerator	370	370	370	436	436
Denominator	715	715	715	742	742
Data Source					National CSHCN Survey
Check this box if you cannot report the numerator because					

1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	64.8	66.9	68.4	70.2	70.2

Notes - 2008
Note 2008: Data only available from The National Survey of Children with Special Health Care Needs Chartbook 2005-2006 HRSA for Mississippi Children.

Mississippi is scheduled to begin the 2010 Needs Assessment as early as August 2009. As a part of this process, future performance objectives will be reviewed and revised as needed.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

a. Last Year's Accomplishments
About 89% of CMP enrollees have insurance to cover the services they need. CMP continues to serve as a payer of last resort for needed services. Insurance status and options are reviewed at each clinic visit.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Include insurance information on CMP applications		X		
2. Verify insurance status at all patient encounters and make referrals to other sources		X		
3. Maintain CMP data system to capture pertinent information				X
4. Continue to work with Medicaid insurers and advocacy groups to promote adequate health coverage for CSHCN				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
CMP assesses insurance needs of all enrollees at the time of application processing. Every other opportunity is taken to assess enrollee's insurance needs. Support services are provided to assist enrollees in resolving any issues preventing them from obtaining adequate coverage.

c. Plan for the Coming Year

CMP will continue to assess health coverage status of all enrollees and assist families in applying for Medicaid and other available benefits. CMP serves as a payer of last resort for needed services.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	72.9	74.9	76.9	78.9	91
Annual Indicator	68.8	68.8	68.8	90.9	90.9
Numerator	245	245	245	676	676
Denominator	356	356	356	744	744
Data Source					National CSHCN Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	92	92.5	93	93.5	3.5

Notes - 2008
Note 2008: Data only available from The National Survey of Children with Special Health Care Needs Chartbook 2005-2006 HRSA for Mississippi Children.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

LIFE is dedicated to the empowerment of people with significant disabilities to be as independent as and fully involved in their communities as they can be. Life coordinates the provision of devices, equipment, aids, modifications or other services and forms of support. LIFE provides advocacy support, peer counseling. They provide services to over 350 CSHCN and their families in addition to adults.

a. Last Year's Accomplishments
About 2,000 CMP enrollees received services at Blake Clinic and 12 satellite clinics. Providers from University of Mississippi Medical Center and St. Jude's Children's Hospital provide services in regional locations in the state. Two additional clinics were added due to enrollee needs. CMP collaborated with the MS Chapter of American Academy of Pediatrics to provide respite care for 20 families.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide and coordinate 12 community-based CSHCN subspecialty medical clinic sites throughout the state to improve access				X
2. Continue to collaborate with families and providers to work through barriers impacting continuity of care				X
3. Maintain a collaborative relationship with community health centers to provide other needed services				X
4. Facilitate communication between specialty and primary care providers through care coordination initiatives				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

CMP contracts with Living Independence for Everyone (LIFE) to assist families in navigating through the health delivery system, as well as identifying other community resources. The Electronic Resource Directory developed by Children's Medical Program is available as a link on LIFE's webpage. The CMP/Genetics teams continue to provide a significant link between families and providers at the community level. The teams developed relationships with selected Federally Qualified Health Centers or clinics to increase awareness and access to CMP services. CMP and the F2FC are developing a database containing community information centers across the state to enhance efforts to disseminate information concerning medical homes and other community based services to families of CSHCN. The collaborative effort put forth by these entities will help to ensure that families are aware of receiving community based services.

c. Plan for the Coming Year

Mississippi's plan for the coming year relevant to this national measure is to continue its efforts to provide quality services that are accessible to Mississippians who need these services. The Parent Consultant will locate resource centers around the state to provide them with additional education resources on medical home and CSHCN issues.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	13.5	13.8	17.8	21.8	31
Annual Indicator	10.6	10.6	10.6	30.9	30.9
Numerator	10	10	10	104	104
Denominator	94	94	94	337	337
Data Source					National CSHCN Survey

Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	32.5	34	35.8	37.5	37.5

Notes - 2008
Note 2008: Data only available from The National Survey of Children with Special Health Care Needs Chartbook 2005-2006 HRSA for Mississippi Children.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

a. Last Year's Accomplishments
CMP held special transition clinics every month at Blake Clinic, the multi-specialty clinic site, for selected children and families with special needs. Children's Medical Program and LIFE provided transition services to children and families on topics such as transition to community life, peer support, skills support, advocacy, waiver services, information, and occasional referrals to vocational rehabilitation services.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue to partner with agencies and organizations working with adolescents on transition issues		X		
2. Enhance the life-skills clinic for the transition of CSHCN to adulthood		X		
3. Ensure that transition services are discussed with patients at appropriate age levels		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Transition services are being implemented in satellite clinics where adequate professional staff are available. Emphasis continues to be placed on services necessary to transition enrollees to

adulthood i.e., community life, employment and independent living skills and individual education plan support activities. The CMP Youth Advisory Council is participating in transition policy and program decisions. Additional state and local programs are being recruited to provide services in the Transition Clinics.

c. Plan for the Coming Year

Mississippi's plan for the coming year relevant to this measure is to continue to support the Children's Medical Program's (CMP) partnership with Living Independence for Everyone of Mississippi in an effort to help prepare CSHCN for transition into adulthood. Among services necessary to transition to adulthood will be transition to community life, employment and independent living skills, and individualized education plan support activities. CMP will continue to partner with LIFE to provide necessary training and support to transition children and youth to adult healthcare settings. The Family to Family Health Information and Education Center will enhance CMP's efforts to make available training resources and facilitate community participation for CSHCN transitioning to all aspects of adult life. CMP will continue to explore the addition of transition clinics and services to other regional sites around the state.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	89	90	89	89.5	83.5
Annual Indicator	85.8	87.6	83.3	80.5	80.9
Numerator	780	859	750	779	872
Denominator	909	981	900	968	1078
Data Source					MSDH
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	90.5	91	91	91	91

Notes - 2008

2008: Mississippi Immunization rate (4:3:1:3:3) for children by 27 months of age has increased slightly from last year. The data are from the 2008 MS two year old survey for those children who completed the 4:3:1:3:3 series by 27 months of age, whereas PM07 states 19 to 36 months. Data are only available for 0-27 months.

Mississippi is scheduled to begin the 2010 Needs Assessment as early as August 2009. As a part of this process, future performance objectives will be reviewed and revised as needed.

Notes - 2007

Mississippi's Immunization rate (4:3:1:3:3) for children 19-35 months of age has declined over the past few years mainly due to children missing the 4th dose of DTaP. Tracking and follow-up is needed to make sure the MSDH does not miss opportunities to vaccinate. Additional reminder recall systems are being reviewed to be put in place to let parents become aware that shots are

due.

Data reported was pulled from the Mississippi Immnization Annual Two Year Old Survey of children who completed 4:3:1:3:3: series by 27 months of age.

a. Last Year's Accomplishments
According to the 2007 immunization survey of children at 27 months of age, 80.5 percent completed immunizations for Diphtheria, Tetanus, Pertussis, Polio, Measles, Mumps, Rubella, Haemophilus influenzae type b, and hepatitis B.

The Immunization Program hired two adolescent coordinators who are responsible for educating the public about adolescent vaccines. The Program began talks with the Department of Education to form a partnership to address adolescent immunizations in the school districts across the state. The ACIP added several new vaccines to the adolescent schedule. As a result, the program staff provided educational materials on these vaccines to providers who serve the adolescent population. Also, staff recruited providers who serve the adolescent population and are not participants, to join the VFC Program.

There was an increase in the number of providers who enter immunizations into the registry via the web. The Immunization Program advertised for RFPs for a new registry. A vendor was selected and a new registry will be implemented within 12 to 18 months.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. 1. Continue to conduct annual immunization surveys to obtain statistical estimates of immunization rate				X
2. 2. Continue to work with the Mississippi Chapter of the American Academy of Pediatrics (AAP)				X
3. 3. Continue to work with the Mississippi Chapter of the American Academy of Family Physicians (AAFP)				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
According to 2008 immunization survey of children at 27 months of age, 80.9 percent completed immunizations for Diphtheria, Tetanus, Pertussis, Polio, Measles, Mumps, Rubella, Haemophilus influenzae type b, and hepatitis B.

The Immunization Program has a variety of educational brochures and informational packets that are available and distributed to the local health departments for use during health fairs and as handouts. These educational materials are also provided to the VFC Providers to distribute to parents of patients. The Program also has a registry brochure that is distributed as well.

c. Plan for the Coming Year
Mississippi State Department of Health (MSDH) has established an Immunization Task Force comprised of Central Office and District staff to determine what activities should be conducted in

the local health departments to increase immunization rates to meet the National Healthy People 2010 Goal for the 17% of children served by MSDH. The Immunization Task Force will also determine appropriate reports that are needed to conduct tracking, target providers with previous poor performance on site visit reports, and continue good community outreach and public education. The Immunization Program will partner with school districts throughout the state to implement the adolescent platform in middle schools. The program will also emphasize the importance of adults receiving recommended immunizations through education.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	36.7	35.3	32.5	31.1	32
Annual Indicator	33.9	33.1	39.7	40.6	32.7
Numerator	2126	2107	2601	2655	2138
Denominator	62661	63715	65576	65379	65379
Data Source					MSDH-Vital Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	31.8	30.5	30.1	29.7	29.7

a. Last Year's Accomplishments
The birth rate (per 1,000) last year for teenagers age 15 through 17 years was 40.6 per 1,000 live births, which represents an increase from the previous year rate of 39.7 per 1,000 live births.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Support Statewide Abstinence Education Program				X
2. Meet with ministers and church organizations to solicit help in addressing teen pregnancy				X
3. Increase collaboration between adolescent pregnancy prevention programs that focus on minorities				X
4. Collaborate with community health centers in all medically underserved counties				X
5. During postpartum home visits, counsel teens regarding availability of family planning services		X		
6. Work with school nurses on counseling teens regarding risky behaviors and goal setting		X		
7. Counsel children ages 9-18 regarding postponing sex, discussions related to reproductive health and contraception		X		
8. Develop partnerships between Mississippi OB/GYN medical consultants and other providers				X

9.				
10.				

b. Current Activities
The Maternity Program works with the agency Family Planning Title X Program to address teen pregnancy prevention at all 81 county public health departments and service sites by providing family planning and reproductive health services including education, counseling, prevention, and access to contraceptives supplies. The program also funds special initiatives that address certain aspects of teenage pregnancy prevention (education, outreach, clinical services, contraceptive supplies, mentoring, and community involvement). From 2007 to 2008, there was a significant drop in the rate of births measured by this performance measure.

The Adolescent Health Coordinator collaborates with internal and external partners to address teen pregnancy and adolescent sexual and reproductive health issues. The MSDH Office of Child and Adolescent Services Program works closely with the Division of Family Planning to implement strategies, policies and services that reduce the rate of repeat births to adolescent mothers less than 17 years old; to reduce the rate of adolescents at risk of early sexual initiation, teen pregnancy and teen parenthood; and to increase the rate of adolescents receiving comprehensive sexual health education in middle and high schools.

c. Plan for the Coming Year
Mississippi's plan during the coming year is to continue implementing activities aimed at reducing the birth rate for teenagers age 15 through 17 years of age, as well as maintaining collaborative efforts with public health districts and community health centers in all medically underserved counties regarding the provision of free contraceptives to teens.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	25	30	30	30	8
Annual Indicator	17	17	7.4	34.8	29.9
Numerator			2819	12959	11444
Denominator			38041	37277	38296
Data Source					MSDH/National Oral Health Surveys
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	30	30	30	30	30

Notes - 2008

Notes 2008: Numerator is underestimated--the sum includes the number of dental sealants placed through the MSDH dental sealant program and the estimated number of dental sealants placed by the dental private practice delivery system as determined per our FY 2005 Needs Assessment Survey.

An attempt was made to change the 2008 annual performance objective to 30, but the Title V Information System prevented this from occurring. Annual performance objectives going forward were changed to 30 to more accurately reflect the current annual indicator for this performance measure and may be revised in the future as needed.

Notes - 2007
Numerator is underestimated--the sum includes the number of dental sealants placed through the MSDH dental sealant program and the estimated number of dental sealants placed by the dental private practice delivery system as determined per our FY 2005 Needs Assessment Survey.

Notes - 2006
Weighted percentage = 25.6% of third grade children have received preventive dental sealants. (95% CI -- 24.3%-26.8%)

a. Last Year's Accomplishments
During the 2007-2008 school-year:
• 1,624 dental sealants were placed on the permanent first molar teeth of 475 second-grade children at 15 elementary schools in seven of 82 counties.

• 26,746 children at 153 elementary schools received school fluoride mouthrinse in grades K through five and 58 participating schools did not return their participation records.

• An oral health survey of children ages three to five years in Head Start programs was conducted. Mississippi has approximately 220 Head Start centers with an enrollment of 23,743 children in 1,260 classrooms. The survey sampled 10 percent of these centers and of the 2,605 children enrolled at the 22 randomly selected Head Start centers, a total of 2,128 were screened for an overall response rate of 81.7%. Over 83 percent of children were black and 11 percent were non-Hispanic white. Results showed that 55.9 percent of Head Start children had experience with dental caries, and 40.9 percent of children had untreated dental cavities. Forty-one percent of Head Start children were in need of dental treatment and 7.2 percent of children had urgent need for care due to infection, pain or swelling.

As of December 31, 2008, 54.6% of the state's population on public water systems was receiving fluoridated drinking water. This represents an increase of about 276,000 people on public water systems since January 2004 (Source: CDC Water Fluoridation Reporting System). In CY2008, 22 Mississippi communities voluntarily agreed to begin new water fluoridation programs and seventeen new water fluoridation systems were activated to serve about 48,751 people.

In CY 2008, MSDH provided oral health screening for 1,712 adults and 8,379 children statewide. Oral health education was provided to 25,110 people at 306 educational events. The Dental Program provided a 51-foot mobile-dental-clinic called the TDOT (see paragraph below) for a volunteer community-based direct care program in February 2008. This three-day program was held in the City of Clarksdale to provide dental care for children and adults at no charge.

TDOT stands for Tomorrow's Dental Office Today and was a promotional tool used by the Sullivan-Schein company to showcase their products. TDOT was dontated to the MSDH Oral Health Program after Hurricane Katrina struck the Mississippi gulf coast in 2005.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service

	DHC	ES	PBS	IB
1. Implement state oral health plan and measure progress to achieve objectives				X
2. Support and sustain statewide oral health coalition activities				X
3. Expand school-based dental sealant program at eligible public schools			X	
4. Increase number of fluoride varnish programs at Head Start centers			X	
5. Expand proportion of population receiving community water fluoridation			X	
6. Develop oral health surveillance plan and burden of disease report		X		
7. Increase and enhance oral health education and promotion activities		X		
8. Expand community safety net dental care outreach via mobile dental clinic (TDOT)	X			
9.				
10.				

b. Current Activities

The Oral Health program has expanded the number of dental hygienists to enable the program to provide oral health assessment and caries risk determination and deliver preventive fluoride varnish to moderate to high risk children in all nine public health districts. The program obtains Medicaid reimbursement for fluoride varnish treatments provided (up to 2 per year), but the Medicaid program does not reimburse for dental health assessment performed by a licensed dental hygienist. Dental hygienists also provide a second nutrition education contact that includes oral hygiene instruction as a required part of WIC recertification.

The dental sealant coordinator is recruiting FQHCs to participate in the school-based dental sealant program. By March 2009, four FQHCs were recruited to participate and sealants were placed in children at three elementary schools. We are using the CDC-sponsored SEALS database to provide performance reports for participating clinics.

The State Board of Health passed a mandatory water fluoridation regulation in April 2009 that requires public water systems that serve a population of at least 2,000 to install fluoridation systems as sufficient funds are identified by the Department of Health.

c. Plan for the Coming Year

The Oral Health program is collaborating with the Office of Health Data and Research to develop a Burden of Oral Diseases Report and a statewide Oral Health Surveillance Plan. A website for MOHCA was created at http://www.healthyMS.com/MOHCA and we are working to create a regional chapters plan and implement local oral health programs. We will also plan and develop the oral health survey as part of the FY2010 MCH Needs Assessment to measure the burden of dental disease and sealant utilization by school-age children.

We are seeking new FY 2010 funding from the Bower Foundation for Mississippi's community water fluoridation program and will continue efforts to encourage communities to install a water fluoridation program using these funds. We will require additional funding to install community water fluoridation programs if the mandatory regulation is passed.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	8.2	8.2	7.9	7.7	7.5
Annual Indicator	7.9	9.1	8.0	7.6	7.6
Numerator	49	56	50	48	48
Denominator	621884	618595	625620	635195	635195
Data Source					MSDH-Vital Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	7.2	7	6.5	6.1	6.1

a. Last Year's Accomplishments

The death rate last year (2007) of children under 15 years of age by motor vehicle crashes (per 100,000) was 7.6, which is a decrease from the previous year 2006 of 8.0. In 2007, data from MSDH Vital Statistics indicated that injury-related fatalities were the leading cause of death for children ages 1 to 18 years, and the fourth leading cause of death for infants. Motor vehicle crashes continue to account for most injury-related deaths, typically due to misuse or non-use of child occupant restraints and seat belt systems. The rate of motor vehicle-related fatalities in children ages 1- 18 has increased by more than 6% over the last five years, according to MSDH Vital Statistics data. Therefore, the Injury and Violence Prevention Program has continued to target motor vehicle safety and promote correct child occupant protection. In 2008 alone, 5,968 child restraints were distributed across the state of Mississippi. Expansion of the program has involved collaboration with the Pregnancy High Risk Management program, where one district has been selected to pilot the Safety Seat Incentive program. Through this collaboration, the Injury and Violence Program has certified 15 PHRM staff from that district as Child Passenger Safety Technicians and has provided 150 convertible car seats to use as motivational rewards for patient attendance to clinic appointments. Expected outcomes include specific targeting of a high-risk, low-income population and increased compliance with appointment scheduling

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. 1. Collaborate with the Safe Kids of Mississippi Coalition to initiate legislation				X
2. 2. Partner with local health departments to provide child safety seats to residents of Mississippi				X
3. 3. Develop and implement an initiative to educate and provide information to parents on the proper use of child safety seats		X		
4. 4. Utilize educational videos and informational TIPP sheets		X		
5. 5. Maintain MSDH participation with the Mississippi				X

Association of Highway Safety Coalition				
6. 6. Work with school nurses and other school personnel to promote safety education related to MVC				X
7. 7. Identify opportunities for collaboration to enhance safety awareness efforts and interventions				X
8.				
9.				
10.				

b. Current Activities
The MSDH has several preventive health activities aimed at reducing the death rate by motor vehicle crashes through many collaborative efforts and promotions. Some of the activities, programs, and/or other means targeted at reduction of MVC are:

1. Safe Kids of Mississippi Coalition
2. Child Safety Seat program
3. Education and implementation of programs to provide information to parents for proper use of child safety seats.
4. Work with school nurses and other school personnel to promote safety education

The MSDH houses a position called the Child Death Review Panel (CDRP) Coordinator that serves on a panel that has been tasked by the state legislature with gaining a better understanding of the causes and circumstances of unexplained infant and child deaths with the goal of providing recommendations that lead to their reduction. Motor vehicle crashes is one of the Causes of Death categories described in a report that is submitted annually to the state legislature. In 2008, a law was passed mandating booster seats for children of a certain age and size and in 2009 a law was passed strengthening requirements for obtaining graduated driver's licences. Representatives from organizations such as the MS Department of Human Services, the State Medical Examiner's Office, March of Dimes, University of Mississippi Medical Center, and the Attorney General's office serve on this panel and collaborate on advocacy issues and related legislation.

c. Plan for the Coming Year
Continue to work with different agencies and community based organizations to develop initiatives to reduce MVC rates for the targeted age group under 15 years of age.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			16.3	16.5	18.5
Annual Indicator		16.2	12	18	8.3
Numerator					
Denominator					
Data Source					MS PRAMS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year					

moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	18.6	18.9	19.1	19.5	19.5

Notes - 2008
Data from the Ross Mothers Survey are unavailable at this time; data from the MS PRAMS survey were substituted for 2008. The 2004 and 2006 data were combined to increase sample size and the six-month breastfeeding percentage was calculated using a specific SAS/SUDAAN programming algorithm. Because of the differences from the Ross Mother Survey and the MS PRAMS survey, PRAMS will be utilized in the future since it is administered each year in Mississippi.

Mississippi is scheduled to begin the 2010 Needs Assessment as early as August 2009. As a part of this process, future performance objectives will be reviewed and revised as needed.

Notes - 2007
According to the latest data available from Ross Mother Survey (2006), 18 percent of mothers surveyed breastfed their infants at 6 months of age.

Notes - 2006
According to the latest data available from Ross Mother Survey, 12 percent of mothers surveyed breastfed their infants at 6 months of age.

a. Last Year's Accomplishments
Activities certifying and promoting breastfeeding among women in Mississippi were utilized to improve the incidence and duration of breastfeeding. Education and training to reduce natural and artificial barriers to breastfeeding along with public awareness was the focus of several WIC related activities.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. 1. Certify and promote MSDH clinics as breastfeeding friendly facilities		X		
2. 2. Continue the nationally recognized peer counselor breastfeeding program throughout the Mississippi State Department of Health		X		
3. 3. Continue the implementation of USDA National Breastfeeding Promotion Campaign		X		
4. Distribute a promotional video to assist WIC clients, physician clinics and hospitals		X		
5. 5. Provide technical training opportunities for health care provides on breastfeeding promotion		X		
6. 6. Conduct outreach activities with worksites targeting women childbearing populations		X		
7. 7. Increase collaboration among Mississippi State Department of Health agency programs and private providers				X
8. 8. Continue to partner with the March of Dimes to encourage providers to apply for funding to provide patient education				X
9.				
10.				

b. Current Activities

Current activities continue to promote implementing initiatives to improve the incidence and duration of breastfeeding among women in Mississippi. These activities include certifying and promoting videos to assist WIC clients, physician clinics and hospitals with ways to address breastfeeding barriers. The Breastfeeding Gold Standard Conference was held in Jackson, MS, in May of 2009. A pre-conference summit was held at the Mississippi State Department of Health where guest speakers from organizations such as institutions of higher learning, the Mississippi Division of Medicaid, and hospitals discussed the benefits and initiatives currently being promoted in the state. Findings from the summit included twelve specific recommendations that included: encourage breastfeeding courses in medical and nursing programs, initiate outreach and education to support breastfeeding women in the workplace, broaden the scope of PRAMS data by including questions regarding the care women received during hospitalization regarding breastfeeding initiation and support, increase access to high quality breast pumps for all mothers who are breastfeeding upon hospital discharge through coverage for breast pumps in the Durable Medical Equipment (DME) benefit of Medicaid and coverage for those receiving health insurance from other health insurers in Mississippi, and provide outreach to all physicians and health care providers about the public health imperative of breastfeeding.

c. Plan for the Coming Year

Mississippi's plan for the coming year relevant to this national measure is to continue implementing initiatives to improve the incidence and duration of breastfeeding among women in Mississippi. These initiatives will include continuing activities such as certifying and promoting videos to assist WIC clients, physician clinics and hospitals with ways to address breastfeeding barriers. MSDH will continue to promote public health activities related to breastfeeding education through the use of coalitions, summits, and public health district meetings throughout the state of Mississippi.

MSDH also intends to adopt and promote a breatfeeding policy to encourage and support the act of breastfeeding among new mothers in the employ of the agency. This policy is based on HRSA materials entitled "Business Case for Breastfeeding" and will be used as a springboard to initiate and/or continue discussions with Mississippi Medicaid and Blue Cross/Blue Shield of Mississippi to provide lactation support for agency employees and other eligibles in the state.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	99.3	99.5	99.6	99.7	99.7
Annual Indicator	96.7	98.5	98.6	99.9	98.7
Numerator	40921	40453	44238	45456	44900
Denominator	42321	41062	44863	45509	45500
Data Source					MSDH
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	99.8	99.8	98.8	98.8	98.8

Notes - 2007
Mississippi's birth cohort was not used here, but the number 44,863 was used which represents the total births in Mississippi for 2006 minus the children born outside of the state and not screened in Mississippi.

Notes - 2006
2006 data for this measure are currently unavailable. However, data for this measure was calculated using a simple linear regression formula.

a. Last Year's Accomplishments
During Calendar Year (CY) 2007, 45,456 (99.86%) infants received hearing screening prior to hospital discharge. Extensive training was conducted at all screening facilities to ensure competence of hospital staff in effectively completing the screening procedures and providing timely referral for infants not passing the screening.

For CY 2008, provisional data indicate that 98.7% of infants received hearing screening prior to discharge. This percentage is expected to increase when reports and birth files are reconciled. Policies and procedures have been updated to reflect current operations and practices to reduce loss to follow-up.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide technical support to hospitals with regard to the screening process and upgrading equipment				X
2. Receive and review written, electronic and faxed reports from birthing hospitals and /or facilities				X
3. Review screening reports for risk factors		X		
4. Monitor referral of infants to diagnostic centers for confirmation of hearing loss		X		
5. Provide literature to hospitals for distribution to parents regarding pass/refer status, follow-up recommendations, and parent support		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Currently, 2008 provisional data estimate that 44,900 (98.7 %) infants were screened prior to hospital discharge. Extensive training continues to be conducted at all screening facilities to ensure competence of hospital staff in effectively completing the screening procedures and providing timely referral for infants not passing the screening.

MSDH is also working to improve data collection on children who refer and those at risk for late onset of hearing impairments.

c. Plan for the Coming Year
Plans for the coming year for the EHDI-M program include: working closely with the Louisiana State Department of Health to create a new policy pertaining to newborns born on the border of Mississippi and Louisiana, purchasing an additional Automated Auditory Brainstem Response (AABR) unit to be used as a loaner for hospitals screening newborns, and reduce loss to follow-

up by increasing collaboration with hospitals, families, and providers. MSDH owns 5 portable Automated Auditory Brainstem Response (AABR) units that will be used by hearing resource consultants, two of which are licensed audiologists. This equipment will be used to screen children not screened in the hospital or lost to follow-up between first and second screenings.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	14.5	10.5	10.4	10.3	12
Annual Indicator	10.8	10.8	13	12.6	14
Numerator					
Denominator					
Data Source					Kids Count DataBook
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	11.5	11.1	10.9	10.2	10.2

Notes - 2008
Data extracted from The Annie E Casey Foundation, 2008 Kids Count DataBook, Mississippi Data page 112.

Mississippi is scheduled to begin the 2010 Needs Assessment as early as August 2009. As a part of this process, future performance objectives will be reviewed and revised as needed.

Notes - 2007
Source: Medicaid Facts; January 2007
National Asssociation of Children's Hospitals.

Notes - 2006
Data for this measure were taken from the Mississippi Profile Fact Sheet reported in the Kaiser Family Foundation 2005 report.

a. Last Year's Accomplishments
Data for 2007 revealed 12.6% of children in the state of Mississippi were without health insurance from National Association of Children's Hospitals.

MSDH continues to work with Medicaid to house outstationed eligibility workers in local health departments in an effort to increase Medicaid and SCHIP enrollment and recertification.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**

1. 1. Work with Medicaid to address issues and barriers to applying and receiving Medicaid and SCHIP				X
2. 2. Facilitate dialogue with stakeholders to work with insurance companies to improve access to health coverage for children		X		
3. 3. Assess health coverage status at every opportunity and provide assistance to families in the completion of applications		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Data extracted from The Annie E Casey Foundation, 2008 Kids Count DataBook, Mississippi Data page 112 revealed 14% of Mississippi children were without health insurance.

We continue to assess health coverage status at every opportunity and refer families to Medicaid's outstation eligibility sites for enrollment and recertification as indicated.

c. Plan for the Coming Year

Mississippi continues to work with different agencies in an effort to increase the collaboration of these groups to help identify uninsured children and expand the awareness of available health coverage groups. This is being done at the state agency level, with advocacy groups, and various volunteer projects throughout the state.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			33.5	33.2	32
Annual Indicator		33.7	32.5	33.0	16.5
Numerator		13626	11892	6719	12552
Denominator		40391	36643	20376	76107
Data Source					MSDH-WIC
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	31	30	29	29.5	29.5

Notes - 2008

Mississippi is scheduled to begin the 2010 Needs Assessment as early as August 2009. As a part of this process, future performance objectives will be reviewed and revised as needed.

a. Last Year's Accomplishments
Last year, according to WIC data for 2007, 33.0% of children ages 2-5 receiving WIC services had a Body Mass Index (BMI) at or above the 85 percentile.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. 1. Conduct nutrition education and encourage WIC clients to make appropriate food choices and exercise				X
2. 2. Customize food packages to family needs			X	
3. 3. Recommend and promote healthy lifestyle changes			X	
4. 4. Continue to implement the Value Enhanced Nutrition Assessment			X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Presently, WIC data indicates that there are 16.5 percent of children ages 2-5 receiving WIC services with a Body Mass Index (BMI) at or above the 85 percentile.

c. Plan for the Coming Year
The WIC food package has been re-designed and will provide fruits and vegetables to its eligible participants. This will be a beneficial addition to the existing food package and provide some healthy choices for the recipients of the WIC services.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective			21.7	21.5	13.5
Annual Indicator		21.9	14.6	14.4	14.9
Numerator		318	147	209	183
Denominator		1453	1009	1453	1228
Data Source					MS-PRAMS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

	2009	2010	2011	2012	2013
Annual Performance Objective	13.5	13.2	13	12.5	12.5

Notes - 2007
Source: Estimates for PRAMS 2006 Analysis.

Notes - 2006
Source: PRAMS 2006 Analysis.

a. Last Year's Accomplishments
PRAMS data revealed 14.0% of women smoke in the last months of pregnancy. The Mississippi State Department of Health provides funds and resources to the agency's health educators to increase awareness of tobacco cesssation services among pregnant women in Mississippi.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. 1. Work with nurses and health educators to increase health education		X		
2. 2. Provide training related to smoking cessation for nurses, nutritionists, and social workers for educating those populations effected by smoking during pregnancy		X		
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Again the MSDH continues to provide funds and resources to the agency's health educators to increase awareness of tobacco cesssation services among pregnant women in Mississippi. Promotion of the Mississippi Tobacco Quitline and the ACT Center for Tobacco Education, Treatment and Research by MSDH helps increase awareness.

c. Plan for the Coming Year
MSDH will provide funds to organizations who serve this special population to provide tobacco prevention education and promote cessation services.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	9.2	7.9	7.9	7.7	7
Annual Indicator	8.8	8.8	5.9	10.4	7.7
Numerator	19	19	13	23	17
Denominator	216248	216518	220823	221505	221505

Data Source					MSDH-Vital Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	6.9	6.4	6.1	5.9	5.9

Notes - 2008
Mississippi is scheduled to begin the 2010 Needs Assessment as early as August 2009. As a part of this process, future performance objectives will be reviewed and revised as needed.

a. Last Year's Accomplishments
In 2007, homicide and suicide, along with accidents, accounted for the top three causes of deaths for teenagers aged 15 to 19 years. Therefore, intentional youth violence continues to be a desired target of educational programming and intervention implementation. The Injury and Violence Prevention Program has partnered with the Mississippi Department of Mental Health to implement school-based suicide prevention efforts in areas of the state with the highest frequency of teen suicides.

Several local and regional training sessions were held that addressed awareness and prevention strategies. The MS Youth Suicide Advisory Council met regularly to plan strategy for efforts to address the issue of suicide prevention.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. 1. Develop strategies for utilization of school health nurses as a school and community resource for health education and to assist in bridging the communication gaps between adolescents and their families				X
2. 2. Collaborate with the Mississippi State Department of Mental Health to explore initiatives for preventing suicide deaths among youths, such as suicide risk assessments and prevention				X
3. 3. Review records to screen for high risk youth		X		
4. 4. Provide information on available resources thoughout the state from various suicide prevention networks		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
CY 2008 estimated suicide death rate in Mississippi (per 100,000) among youths 15-19 is 7.7. The Mississippi Department of Mental Health utilizes a grant to implement youth suicide prevention activities. Public health and school nurses were available to provide counseling and

referral services to youth identified to be at risk by acting as a school and community resource for health education.

c. Plan for the Coming Year
The Mississippi State Department of Health will continue its collaboration with key stakeholders of the Mississippi Youth Suicide Advisory Council to develop strategies to address youth suicide in the state.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	33	34	32.7	32.6	32.5
Annual Indicator	31.2	30.5	28.6	28.1	32.0
Numerator	297	301	310	291	331
Denominator	952	988	1083	1035	1035
Data Source					MSDH-Vital Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	32.3	32.2	32.1	32.5	32.5

a. Last Year's Accomplishments
During CY2007 28.1 percent of very low birthweight infants were delivered at tertiary centers. This represents a slight decrease from 28.6 in CY2006.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. 1. Continue to work with the Mississippi Perinatal Association and the March of Dimes to evaluate the regionalization system in Mississippi				X
2. 2. Evaluate the current system and develop a plan of improvement if needed				X
3. 3. Continue to conduct annual hospital surveys to obtain status of available manpower for multiple medical services, including maternity and newborn		X		
4. 4. Assess facility availability across the state for perinatal practices and statistics for use in state planning		X		
5. 5. Continue to provide financial assistance to the tertiary center for newborn transport		X		
6.				
7.				

8.				
9.				
10.				

b. Current Activities
During 2008, according to provisional data, an estimated 32.0 percent of very low birthweight infants were delivery at tertiary centers. This represents an increase from 28.1 percent reported in CY2007.

Factors that impact this performance measure are a lack of tertiary care facilities in Mississippi (University Medical Center in Jackson is the only tertiary care facility in Mississippi) and a lack of insurance coverage prior to pregnancy [Medicaid coverage in Mississippi only provides coverage prior to pregnancy if separate eligibility requirements are met (e.g. low income with children under 18)].

c. Plan for the Coming Year
Mississippi's plan for the coming year relevant to this national measure is to increase the percent of very low birthweight infants delivered at facilities for high-risk deliveries and neonates by continuing to work with the Mississippi Perinatal Association, the Infant Mortality Task Force, the March of Dimes, and other partners to evaluate the regionalization system in the state.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	85.1	86	86	86.9	87.7
Annual Indicator	81.8	81.4	81.4	81.1	84.8
Numerator	35036	34455	37461	37658	39394
Denominator	42809	42327	46046	46455	46455
Data Source					MSDH-Vital Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	88.6	89.5	90.1	91.4	91.4

a. Last Year's Accomplishments
During CY2007, 81.1 percent of infants born were to women who had received prenatal care beginning in the first trimester. This represents a slight decrease from 81.4 percent reported for CY2006.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**

	DHC	ES	PBS	IB
1. 1. Collaborate with Medicaid and Mississippi State Department of Human Services to include AFDC checks and Food Stamp mailouts with information on prenatal care, WIC, and family planning	X			
2. 2. Collaborate with Mississippi Food Network to distribute information about prenatal care				X
3. 3. Collaborate with the March of Dimes to develop media materials related to early prenatal care				X
4. 4. Collaborate with the Healthy Baby Campaign, a multi-state campaign, to provide coupons for pregnant women who initiate and continue prenatal care				X
5. 5. Collaborate with March of Dimes to implement Stork Nests for clients receiving continuous prenatal care 5. Collaborate with March of Dimes to implement Stork Nests for clients receiving continuous prenatal care				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

During CY 2008, provisional data estimate that approximately 84.8 percent of infants born were to women who had received prenatal care beginning in the first trimester. This represents a slight decrease from 81.4 percent reported for CY2007.

c. Plan for the Coming Year

Pilot programs have been implemented in two areas of the state which include outreach programs that include identifying high risk women and promoting early entry into prenatal care.

D. State Performance Measures

State Performance Measure 1: *Percent of children on Medicaid and SCHIP who receive EPSDT and preventive health services well child visits.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective			35	37	40
Annual Indicator		33.4	27.5	35.3	39.2
Numerator		134265	145798	145775	168529
Denominator		401799	530716	412552	429844
Data Source					MS-Medicaid MSDH
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	42	45	45	45	45

Notes - 2008

Data provided by State of Mississippi, Division of Medicaid, April 8, 2009--SCHIP

a. Last Year's Accomplishments
During CY 2007, of the 412,552 Medicaid eligible children (0-20 years old), 145,775 (35.3%) received screening services. The MSDH continues to work with the Division of Medicaid, Head Start, and other community partners to increase the EPSDT screening participation rate. We continue to collaborate and investigate strategies to provide screening in non-traditional settings and after-hours to facilitate access to services.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. 1. Encourage parents during postpartum home visits to take advantage of EPSDT screenings				X
2. 2. Provide information about EPSDT in WIC packets		X		
3. 3. Remind parents at immunization visits about the importance of EPSDT and to seek health care		X		
4. 4. Check whether EPSDT screenings are due on children being seen for WIC services and screen if needed				X
5. 5. Develop a plan to provide and ensure EPSDT services to all eligible children in the state				X
6. 6. Conduct mass EPSDT screening in select areas		X		
7. 7. Support funding sources to school nurses to perform EPSDT screening				X
8.				
9.				
10.				

b. Current Activities
During CY 2008, of the 429,844 Medicaid eligible children (0-20 years old), 168,529 (39.2) received screening services. The MSDH will continue to work with the Division of Medicaid, Head Start, and other community partners to increase the EPSDT screening participation rate. When possible, screenings are provided in non-traditional settings and after-hours to facilitate access to services.

c. Plan for the Coming Year
The MSDH's plan for the coming year relative to this measure is to continue its efforts to provide increased access to health care for children on Medicaid. The MSDH will continue to encourage parents during prenatal care and postpartum home visits to take advantage of EPSDT screenings. Parents will also be provided information about EPSDT screening at immunization visits and in WIC packets. Mass EPSDT screenings will be conducted in selected areas of the state as well.

State Performance Measure 2: *Current percent of cigarette smoking among adolescents grades 6-12.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective			21	20.5	19
Annual Indicator	21.0	21.0	21.0	19.2	20.2
Numerator	597	597	597	289	321
Denominator	2843	2843	2843	1504	1588
Data Source					YTS
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	19	18.5	18.5	18	18

Notes - 2007
YRBS data reported represent students in grades 9-12. Data are not captured for grades 6-12. "Current use" is defined as use of tobacco product on one or more occasions in the past 30 days preceding the survey.

a. Last Year's Accomplishments
The MSDH provided funds to statewide tobacco control organizations for the implementation of the following youth tobacco prevention programs: Students Working Against Tobacco (SWAT) for youth in grades 4-6; FREE for youth in grades 7-8; Frontline, a youth advocacy program, for youth in grades 9-12; and, TATU, a tobacco prevention and mentoring program, for youth in grades 9-12. The youth tobacco prevention programs provided opportunities for students to have an active role in tobacco prevention by joining SWAT/FREE/Frontline/TATU Teams and conducting monthly activities. The youth programs were implemented in such venues as schools, social organizations, faith-based organizations and after school programs. In addition, MSDH conducted a media campaign to educate youth on the dangers of tobacco use and the importance of making positive, healthy lifestyle choices.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. 1. Through EPSDT, Family Planning and other adolescent visits, counsel youths about tobacco use		X		
2. 2. Maintain community-based tobacco prevention programs in collaboration with the Patrnership				X
3. 3. Maintain use of tobacco prevention curricula in school through the school health nurses				X
4. 4. Conduct site visits to at least 15 schools to assess tobacco prevention activities				X
5. 5. Train staff on smoking cessation specifically targeted to adolescents				X
6. 6. Make literature available to communities and schools on smoking cessation		X		
7.				
8.				
9.				
10.				

b. Current Activities
The MSDH provides funds to statewide tobacco control organizations for the implementation of the following youth tobacco prevention programs: Reject All Tobacco (RAT) for youth in grades 4-6; FREE, a youth tobacco control advocacy program, for youth in grades 7-12; and, TATU, a youth tobacco prevention and mentoring program, for youth in grades 9-12. The

youth tobacco prevention programs provide opportunities for students to have an active role in tobacco prevention by joining RAT/FREE/TATU Teams and conducting monthly activities. The youth programs are implemented in such avenues as schools, social organizations, faith-based organizations and after school programs. Youth involved in the programs participate in contests throughout the year, and youth involved in the FREE and TATU programs are provided with opportunities to participate in youth leadership and advocacy trainings have. The MSDH also provides funds for the implementation of the Face Reality Spit Tobacco Program, a smokeless tobacco prevention program that is implemented in middle school and high school throughout the state. In addition, MSDH conducts media campaigns to educate youth on the

c. Plan for the Coming Year
The MSDH will continue to provide funds to statewide tobacco control/public health organizations for the implementation of the following youth tobacco prevention programs: Reject All Tobacco (RAT) for youth in grades 4-6; FREE, a youth tobacco control advocacy program, for youth in grades 7-12; and, TATU, a youth tobacco prevention and mentoring program, for youth in grades 9-12. A media campaign will also be conducted to educate youth on the dangers of tobacco, and special youth events (contest, youth summits) will be implemented throughout the year.

State Performance Measure 3: *Percent of pregnant women who smoke*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective			11.7	11.5	11.2
Annual Indicator		11.8	11.8	11.8	14.4
Numerator		5067	5067	5067	4015
Denominator		42809	42809	42809	27893
Data Source					MS PRAMS
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	11	10.5	10.5	10.5	10.5

Notes - 2008
Data calculated from MS PRAMS 2007 dataset.

Notes - 2007
Data for this measure are the latest weighted PRAMS data available. (2004)

Notes - 2006
Data for this measure are the latest weighted PRAMS data available.

a. Last Year's Accomplishments
The MSDH provided funds and resources to the agency's health educators to increase awareness of tobacco cessation services among pregnant women. The MSDH also provided funds for and promoted the services of the Mississippi Tobacco Quitline, a free-of-charge, telephone-based cessation counseling service that implements special counseling protocol for women who are pregnant, and the ACT Center for Tobacco Education, Treatment and Research, a free-of-charge, face-to-face counseling service available at hospitals throughout the state. In addition, the MSDH provided funds to organizations who serve this special population to provide tobacco prevention education and promote cessation services.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. 1. Work with nurses and health educators to increase health education		X		
2. 2. Continue to educate pregnant women receiving services on the dangers of prenatal smoking		X		
3. 3. Provide training about smoking cessation and pregnancy to nurses, nutritionists, and social workers		X		
4. 4. Refer to PHRM/ISS		X		
5. 5. Refer to Tobacco Quitline Mississippi for information on smoking cesssation		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The MSDH provides funds and resources to the agency's health educators to increase awareness of tobacco cessation services among pregnant women. The MSDH also provides funds for and promotes the services of the Mississippi Tobacco Quitline and the ACT Center for Tobacco Education, Treatment and Research. The ACT Center conducts cessation intervention trainings for MSDH health care providers in each public health district. In addition, the MSDH provides funds to organizations who serve this special population to provide tobacco prevention education and promote cessation services.

c. Plan for the Coming Year

The MSDH will provide funds for and promote the services of the Mississippi Tobacco Quitline and the ACT Center for Tobacco Education, Treatment and Research. The ACT Center will also conduct cessation intervention trainings for MSDH health care providers in each public health district. The MSDH will also provide funds to organizations who serve this special population to provide tobacco prevention education and promote cessation services.

State Performance Measure 4: *Percent of children with genetic disorders identified through the MSDH newborn screening program who receive case management services.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	97	98	98.5	98.5	100
Annual Indicator	99.5	100.0	100.0	100.0	100.0
Numerator	2977	100	136	120	116
Denominator	2992	100	136	120	116
Data Source					MSDH-Health Services-Genetics Program
Is the Data Provisional or Final?				Final	Provisional

	2009	2010	2011	2012	2013
Annual Performance Objective	1	1	1	1	1

a. Last Year's Accomplishments
Last year, approximately 100 percent of children with possible genetic disorders received case management services. All newborn screens with inconclusive, abnormal, or presumptive positive test results are reported to genetics field staff for follow-up. Field staff work with local health department nurses to contact the families of these babies by phone or home visits to arrange for counseling and case management. They repeat the screens or collect diagnostic specimens if needed, and arrange for medical evaluation and treatment or other intervention if indicated. Children diagnosed with genetic disorders receive medical care and case management through local physicians, county health departments, the University of Mississippi Medical Center, other treatment centers, and MSDH satellite clinics. Case Management services are limited for some infants with inconclusive results at screening due to the inability to locate families or refusal of service by families.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Report all inconclusive, abnormal, and presumptive positive test results to genetics field staff for counseling, clinic appointments, and follow-up		X		
2. Contact families of babies with inconclusive, abnormal, or presumptive positive test results by phone or home visit, and arrange for counseling or case management		X		
3. Repeat newborn screens or collect diagnostic specimens as needed, and arrange for medical evaluation and treatment if indicated		X		
4. Assure that children diagnosed with genetic disorders have a local medical home and are being followed by a specialty provider as indicated				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The program's current activities include continued education on the importance of newborn screening to health care providers, parents, the public and public health staff.

c. Plan for the Coming Year
Mississippi's plan for this measure is to ensure that children testing positive for genetic disorders receive appropriate case management services. This will be achieved by reporting all positive test results to genetic field staff for clinic appointments and follow-up, and conducting home visits on positive cases for case management.

State Performance Measure 5: *The Rate of Repeat Birth (per 1000) for Adolescents Less Than 18 Years Old*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	13.2	12.5	120	116	112
Annual Indicator	125.5	127.5	141.3	147.7	147.7
Numerator	289	292	392	415	415
Denominator	2303	2290	2774	2810	2810
Data Source					MSDH-Vital Statistics
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	108	104	104	104	104

Notes - 2006
During past years, Mississippi's Annual Performance Objectives were entered as percentages instead of rates. In an effort to correct this error, 2006 and following performance objectives will be listed as rates.

a. Last Year's Accomplishments
During CY 2007 the rate of repeat births per 1,000 female teenagers in Mississippi less than 18 years was 147.7 per 1,000 births to teenagers. The MSDH will continue to sponsor collaborative training such as conferences and male involvement workshops, and support training of MCH/Family Planning nurses to ensure their understanding of the problem of repeat adolescent pregnancies and the benefits of family planning and inter-pregnancy spacing.

The Delta Hills Public Health District III Teenage Pregnancy Prevention Project was funded to provide education to adolescents and teens 18 years of age and younger in order to increase the number of males and females participating in family planning and reproductive health measures as a way of preventing pregnancy and understanding their own reproductive health needs. Areas targeted include issues of self-esteem and understanding the tools available to make informed decisions about their health needs.

The Youth Opportunities Unlimited Boyz-to-Men Project addresses male responsibility in preventing teenage pregnancy, responsible behaviors, and mentoring to younger boys. The goal of the program is to expand and enhance its efforts to teach 800 preadolescent and adolescent males to act responsibly with respect to their sexual and reproductive health choices.

The Mississippi Coalition Against Sexual Assault Program was funded to educate youths and parents about sexual coercion and violence, help them develop skills and behaviors to decrease their vulnerability, improve parenting skills, and offer family planning information about abstinence and other methods. In addition, the program provided training to health professionals outside of the public health setting about how to counsel and provide an understanding of the importance of family planning and reproductive health services to women, men and teens.

The Northwest Public Health District I Improving Health Care for Hispanic Women Program was funded to address the language barriers of Hispanic women as they present to the public health clinic by providing interpreter/translator services and addressing the needs of Hispanic teens in the area (counseling, focus groups, and access to services and contraceptive supplies).

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. 1. Continue to sponsor, through Mississippi State Department of Health's Family Planning Program, collaborative training				X
2. 2. Continue to support the training of Mississippi State Department of Health's Family Planning Program (MSDH/FP) Coordinators				X
3. 3. Continue to work with staff to make prevention of repeat adolescent pregnancies a priority				X
4. 4. Encourage health departments to provide enchanced family planning services to adolescents				X
5. 5. Partner with March of Dimes				X
6. 6. Continue to collaborate with Delat Health Partners				X
7.				
8.				
9.				
10.				

b. Current Activities

During CY 2008, the rate of repeat births per 1,000 female teenagers in Mississippi less than 18 years was 147.7 per 1,000 births to teenagers. The MSDH will continue to sponsor collaborative training such as conferences and male involvement workshops, and support training of MCH/Family Planning nurses to ensure their understanding of the problem of repeat adolescent pregnancies and the benefits of family planning and inter-pregnancy spacing. MSDH will also continue to partner with the Department of Education to promote healthy behaviors among Mississippi adolescents.

c. Plan for the Coming Year

The MSDH will continue to sponsor, through its Family Planning Program, collaborative training such as conferences and male involvement workshops, and work with local health department staff to make prevention of repeat adolescent pregnancy a priority in care plans for teen clients. The MSDH will also continue to partner with the Mississippi Chapter of the March of Dimes to implement at least one Project Alpha Program in the state to increase healthy lifestyle behaviors among adolescent males through education and responsible decision-making.

State Performance Measure 6: *Percent of children ages 0-5 on WIC classified as overweight*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective			12.8	12.5	12.2
Annual Indicator		13.0	12.7	15.4	16.5
Numerator		5248	4668	8519	12552
Denominator		40391	36643	55318	76107
Data Source					MS-WIC
Is the Data Provisional or Final?				Final	Provisional

	2009	2010	2011	2012	2013
Annual Performance Objective	12	11.8	11.8	11.8	11.8

Notes - 2008
Data received from Mississippi WIC based on total children ages 2-5 years old (76,107) and with BMI >= 85%, 12,552 for period January 1, 2008 thru December 31, 2008.

Notes - 2007
WIC dataset was obtained and analysis was peformed on the raw data. The 2007 Percent of children ages 0-5 on WIC classified as overweight was recalculated and the percentage was approximately 15.4%. This recalculation is in line with the previous years and with the provisional data for 2008. Source of data was archived WIC access dataset.

Notes - 2006
Statistics could only be provided for ages 2 through 5. We were not able to find the percentile data tables needed to provide statistics for ages 0 to 23 months. Thus, data are for children 2-5 years and children at or above the 95 th percentile to classify overweight.

a. Last Year's Accomplishments
The Nutrition Services program serves in an advisory capacity to programs and services. The primary focus is to encourage a healthier lifestyle, by means of improved nutrition and increased physical activity, throughout the agency and state. Our Fruits and Veggies-More Matters program reached over 24,000 individuals in 2007. Nutrition Services provided pamphlets, recipes, and posters in the clinics for educating our clients on the use of and importance of eating fruits and vegetables in the diet. The Fruits and Veggies-More Matters program has been incorporated in several Head Start programs to encourage the young child to try new foods. Nutrition Services also works with the Child Nutrition Program in the Department of Education to promote Fruit & Veggies-More Matters at school events and education/health fairs.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. 1. Encourage and/or promote breastfeeding of infants		X		
2. 2. Customize food package to meet family needs		X		
3. 3. Encourage healthy lifestyle changes		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Nutrition services are being utilized in promoting changes in regulations for child care facilities. Some of these changes that have occurred are stricter meal guidelines, encouraging physical activity for children, and restricting the use of and products in vending. To also encourage healthier lifestyles in the preschool child and their parent, the department, along with Childcare Licensure, has launched a training program, "Color Me Healthy". This statewide program is for teachers in the preschool setting and targets incorporating food variety and physical activity using all five senses.

c. Plan for the Coming Year
The MSDH WIC program will continue encouraging breastfeeding of infants and implementing VENA, as well as promoting nutrition education classes that encourage WIC clients to make appropriate food choices and exercise.

State Performance Measure 7: *Percent of adolescents in grades 6-12 who are overweight or at risk for becoming overweight*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective			26	26	26
Annual Indicator	27.3	27.3	27.3	35.8	35.8
Numerator	809	809	809	1051	1051
Denominator	2961	2961	2961	2936	2936
Data Source					MS-YRBSS 2007
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	25	25	25	25	25

Notes - 2008
2007 YRBSS is the most recent survey data.

Notes - 2007
Most recent data are from 2007 YRBSS. The percentage was obtained by adding the percentages of the overweight and at risk of becoming overweight groups.

Notes - 2006
Most recent data are from 2003 YRBSS. MS did not receive weighted data for the 2005 YRBSS.

a. Last Year's Accomplishments
The Nutrition Services program serves in an advisory capacity to programs and services. The primary focus is
to encourage a healthier lifestyle, by means of improved nutrition and increased physical activity, throughout
the agency and state. Our Fruits and Veggies-More Matters program reached over 24,000 individuals in 2007.
Nutrition Services provided pamphlets, recipes, and posters in the clinics for educating our clients on the use of
and importance of eating fruits and vegetables in the diet. The Fruits and Veggies-More Matters program
has been incorporated in several Head Start programs to encourage the young child to try new foods. Nutrition
Services also works with the Child Nutrition Program in the Department of Education to promote Fruit &
Veggies-More Matters at school events and education/health fairs.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. 1. Develop and implement health education programs targeting adolescents in grades 6-12 who are overweight or at				X

risk of becoming overweight				
2. 2. Identify and recruit contact persons within the public school system to assist the initiation of health education programs targeting overweight at risk students				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Nutrition services are being utilized in promoting changes in regulations for child care facilities. Some of these
changes that have occurred are stricter meal guidelines, encouraging physical activity for children,
and restricting the use of and products in vending. To also encourage healthier lifestyles in the preschool child
and their parent, the department, along with Childcare Licensure, has launched a training program, "Color
Me Healthy". This statewide program is for teachers in the preschool setting and targets incorporating
food variety and physical activity using all five senses.

c. Plan for the Coming Year
In an effort to address childhood obesity, the MSDH will work to develop and implement health education programs in Mississippi targeting adolescents in grades 6-12 who are overweight or at risk of becoming overweight.

State Performance Measure 8: *Percent of Medicaid eligible children ages 1-5 reported to have had at least one preventive dental service*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			30	30.5	31
Annual Indicator	29.2	3.0	3.0	26.8	30.6
Numerator	33032	3551	4196	38737	41982
Denominator	113311	117827	139273	144787	137231
Data Source					MS-Medicaid Division
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	31.5	32	32	32	32

Notes - 2008
Data provided by State of Mississippi, Division of Medicaid, April 8, 2009

Notes - 2007

The following information was provided by Division of Medicaid, explaining the differences from previous years:

Topical Application of Fluoride became a covered service in January 2007 causing in increase in the number of oral health preventive services received by Medicaid-eligible children agees 1-5, and is reflective in the numerator for 2007 being larger than those in 2004, 2005, and 2006.

Note regarding 2004 data, unable to correct error in 2004 reported information, field is not available for any changes.

Notes - 2006
According to data received from the Division of Medicaid, the numerator for this measure is based on select dental procedure codes for oral health preventive service, and paid claims to dental providers only. The number does not include an oral health preventive service provided by a primary care practitioner.

The following information was provided by Division of Medicaid, explaining the differences from previous years:

Topical Application of Fluoride became a covered service in January 2007 causing in increase in the number of oral health preventive services received by Medicaid-eligible children agees 1-5, and is reflective in the numerator for 2007 being larger than those in 2004, 2005, and 2006.

a. Last Year's Accomplishments
During the 2007-2008 school-year:
- 1,624 dental sealants were placed on the permanent first molar teeth of 475 second-grade children at 15 elementary schools in seven of 82 counties.
- 26,746 children at 153 elementary schools received school fluoride mouthrinse in grades K through five and 58 participating schools did not return their participation records.
- An oral health survey of children ages three to five years in Head Start programs was conducted. Mississippi has approximately 220 Head Start centers with an enrollment of 23,743 children in 1,260 classrooms. The survey sampled 10 percent of these centers and of the 2,605 children enrolled at the 22 randomly selected Head Start centers, a total of 2,128 were screened for an overall response rate of 81.7%. Over 83 percent of children were black and 11 percent were non-Hispanic white. Results showed that 55.9 percent of Head Start children had experience with dental caries, and 40.9 percent of children had untreated dental cavities. Forty-one percent of Head Start children were in need of dental treatment and 7.2 percent of children had urgent need for care due to infection, pain or swelling.

As of December 31, 2008, 54.6% of the state's population on public water systems was receiving fluoridated drinking water. This represents an increase of about 276,000 people on public water systems since January 2004 (Source: CDC Water Fluoridation Reporting System). In CY2008, 22 Mississippi' communities agreed voluntarily to begin new water fluoridation programs and eleven new water fluoridation systems were activated to serve about 38,199 people.

In CY 2008, we provided oral health screening for 1,712 adults and 8,379 children statewide. We also provided oral health education to 25,110 people at 306 educational events. The Dental Program provided a 51-foot mobile-dental-clinic called the TDOT for a volunteer community-based direct care program in February 2008. This three-day program was held in the City of Clarksdale to provide dental care for children and adults at no charge.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. 1. Initiate more water fluoridation programs in communities				X

2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The Oral Health program has expanded the number of dental hygienists to enable the program to provide oral health assessment and caries risk determination and deliver preventive fluoride varnish to moderate to high risk children in all nine public health districts. The program obtains Medicaid reimbursement for fluoride varnish treatments provided (up to 2 per year), but the Medicaid program does not reimburse for dental health assessment performed by a licensed dental hygienist. Dental hygienists also provide a second nutrition education contact that includes oral hygiene instruction as a required part of WIC recertification.

The dental sealant coordinator is recruiting FQHCs to participate in the school-based dental sealant program. By March 2009, four FQHCs were recruited to participate and sealants were placed in children at three elementary schools. We are using the CDC-sponsored SEALS database to provide performance reports for participating clinics.

The State Board of Health is considering a mandatory water fluoridation regulation in April 2009. If passed, public water systems that serve a population of at least 2,000 will be required to install fluoridation system as sufficient funds are identified by the Department of Health.

c. Plan for the Coming Year
The Oral Health program is collaborating with the Office of Health Data to develop a Burden of Oral Diseases Report and a statewide Oral Health Surveillance Plan. A website for MOHCA was created at http://www.healthyMS.com/MOHCA and we are working to create regional chapters plan and implement local oral health programs. We will also plan and develop the oral health survey as part of the FY2010 MCH Needs Assessment to measure the burden of dental disease and sealant utilization by school-age children.

We are seeking new FY 2010 funding from the Bower Foundation for Mississippi's community water fluoridation program and will continue efforts to encourage communities to install a water fluoridation program using these funds. We will require additional funding to install community water fluoridation programs if the mandatory regulation is passed.

E. Health Status Indicators

Introduction
Health status indicators are used by MSDH to identify services needed in all 82 counties in Mississippi. Services include prenatal and postnatal care, well child and sick child care, as well as restorative services for CSHCN. This allows MSDH to address the needs of children and families, especially those with low incomes, in a family-centered, community-based and coordinated manner that ensures access and availability of quality health care.

/2010/ The MSDH anticipates successful completion of the 2010 Needs Assessment next year. Activities are already underway for this project. A plan for the project has been established and supporting funds have been requested. The Health Services Chief Nurse, having prior experience with the 2005 Needs Assessment, will lead the project. During meetings with various MCH stakeholders and other state agencies, notice has been provided on the upcoming assessment and we have begun to explore strategies for partnering and data sharing to accomplish the most extensive assessment possible. //2010//

Health Status Indicators 01A: *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	11.6	11.9	12.4	12.3	12.3
Numerator	4973	5031	5713	5699	5699
Denominator	42809	42327	46046	46455	46455
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Narrative:

/2010/

The percent of live births weighing less than 2,500 grams for 2007 was 12.3% (5,699/46,455) compared to 2006 data 12.4% 5,713/46,046. The estimated percentage for 2008 is also 12.4%. Two programs implemented within the State of Mississippi with components related to reducing the number of births less than 2,500 grams are the DIME and MIME grants. The Healthy People 2010 objective is to reduce low birth weight (LBW) to no more than 5 percent of all live births. //2010//

Health Status Indicators 01B: *The percent of live singleton births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	9.7	9.9	10.2	10.3	10.1
Numerator	4024	4056	4520	4628	4532
Denominator	41403	40871	44386	44879	44879
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Narrative:
/2010/
The percent of live singleton births weighing less than 2,500 grams for 2007 was 10.3% (4,628/44,879) compared to 2006 data 10.2% (4,520/44,386). The estimated percentage for 2008 is 10.1%. Two programs implemented within the State of Mississippi with components related to reducing the number of singleton births less than 2,500 grams are the DIME and MIME grants. While there is not a specific Healthy People 2010 objective for the health status indicator it is related to objective 16-10a: Reduce low birth weights (LBW) to no more than 5 percent of all live births. //2010//

Health Status Indicators 02A: *The percent of live births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	2.2	2.3	2.4	2.2	2.4
Numerator	952	988	1083	1035	1114
Denominator	42809	42327	46046	46455	46455
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Narrative:
/2010/ The percent of live births weighing less than 1,500 grams for 2007 was 2.2% (1,035/46,455) compared to 2.4% (1,083/46,046) for 2006. The estimated projection for 2008 is 2.4% Two programs implemented within the State of Mississippi with components related to reducing the number of births less than 1,500 grams are the DIME and MIME grants. The Healthy People 2010 objective is to reduce very low birth weight births to no more than 0.9 percent of all live births. //2010//

Health Status Indicators 02B: *The percent of live singleton births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	1.9	1.9	1.9	1.8	2.0
Numerator	778	782	829	807	897
Denominator	41403	40871	44386	44879	44879
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Narrative:
/2010/ The percent of live singleton births weighing less than 1,500 grams for 2007 was 1.8% (807/44,879) compared to 1.9% (829/44,388) for 2006. The estimated projection for 2008 is 2.0% Two programs implemented within the State of Mississippi with components related to reducing the number of births less than 1,500 grams are the DIME and MIME grants. While there is not a specific Healthy People 2010 objective for this health status indicator it is related to 16-10b: Reduce very low births weights to no more than 0.9 percent of all live births (using baseline of 1.4 percent in 1998) //2010//

Health Status Indicators 03A: *The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	16.4	17.3	17.3	21.4	17.0
Numerator	102	107	108	136	108
Denominator	621884	618595	625620	635195	635195
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Narrative:
/2010/ The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger was 21.4 in 2007 compared to 17.3 per 100,000 for 2006. The estimated death rate per 100,000 due to unintentional injuries among children aged 14 years and younger is 17.0 (108/635,195x100,000). This is not a Healthy People 2010 objective but this is related to objective 15-13: Reduce deaths caused by unintentional injuries to no more than 20.8 per 1000,000 (baseline: 33.3 deaths per 100,000 in 1998) //2010//

Health Status Indicators 03B: *The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	7.9	9.1	8.0	7.6	7.6
Numerator	49	56	50	48	48
Denominator	621884	618595	625620	635195	635195
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Narrative:
/2010/ The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes was 7.6 in 2007 compared to 8.0 per 100,000 for 2006. The estimated death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes is 7.6 (48/635,195)x100,000. The Healthy People 2010 objective 15-15a: Reduce deaths caused by motor vehicle crashes. (Target 9.0 deaths per 100,000 population--baseline for children aged 14 years and younger, 4.2 in 1998)

The MSDH houses a position called the Child Death Review Panel (CDRP) Coordinator that serves on a panel that has been tasked by the state legislature with gaining a better understanding of the causes and circumstances of unexplained infant and child deaths with the goal of providing recommendations that lead to their reduction. Motor vehicle crashes is one of the Causes of Death categories described in a report that is submitted annually to the state legislature. In 2008, a law was passed mandating booster seats for children of a certain age and size and in 2009 a law was passed strengthening requirements for obtaining graduated driver's licences. Representatives from organizations such as the MS Department of Human Services, the State Medical Examiner's Office, March of Dimes, University of Mississippi Medical Center, and the Attorney General's office serve on this panel and collaborate on advocacy issues and related legislation.

Motor vehicle crashes account for most injury-related deaths, typically due to misuse or non-use of child occupant restraints and seat belt systems. In order to assure this indicator continues to decrease, the Injury and Violence Prevention Program will carry forward its efforts to target motor vehicle safety and promote correct child occupant protection. In 2008 alone, 5,968 child restraints were distributed across the state of Mississippi. Expansion of the program has involved collaboration with the Pregnancy High Risk Management program, where one district has been selected to pilot the Safety Seat Incentive program. Through this collaboration, the Injury and Violence Program has certified 15 PHRM staff from that district as Child Passenger Safety Technicians and has provided 150 convertible car seats to use as motivational rewards for patient attendance to clinic appointments. Expected outcomes include specific targeting of a high-risk, low-income population and increased compliance with appointment scheduling. //2010//

Health Status Indicators 03C: *The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	49.0	48.5	51.2	50.9	46.6
Numerator	221	216	224	222	203
Denominator	450835	445425	437470	435916	435916
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Narrative:
/2010/ The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth 15 through 24 years for 2007 was 59.9 deaths per 100,000 compared to 51.2 for 2006. The estimated death rate per 100,000 from unintentional injuries due to MVC (youth aged 16-24) is 46.6 for 2008. The Healthy People 2010 objective 15-15a: Reduce deaths caused by motor vehicle crashes. (Target 9.0 deaths per 100,000 population-baseline for persons 15-24 years, 25.4 deaths per 100,000 in 1998) //2010//

Health Status Indicators 04A: *The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	17,229.3	424.2	427.4	344.5	344.5
Numerator	2414	2636	2644	2188	2188
Denominator	14011	621381	618595	635195	635195
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
Denominator in 2004 was not total population for specified age range. This has been corrected. Through this correction, MS now has a true rate per 100,000, however, this correction caused a discrepancy in data from years 2004 to 2005.

Narrative:
/2010/ The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger was 344.5 in 2007 compared to 427.4 in 2006. The estimated rate for 2008 is also projected to be 344.5 based on 2,188 injuries from a population group comprised of 635,195 individuals aged 14 years and younger. The Healthy People 2010 objective is not specific for this health status indicator it is related to objective 15-14: Reduce non-fatal unintentional injuries. //2010//

Health Status Indicators 04B: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	12,943.1	160.0	192.7	145.0	145.0
Numerator	1048	994	1192	921	921
Denominator	8097	621381	618595	635195	635195
Check this box if you cannot report the numerator because					

1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
Denominator in 2004 was not total population for specified age range. This has been corrected. Through this correction, MS now has a true rate per 100,000, however, this correction caused a discrepancy in data from years 2004 to 2005.

Narrative:
/2010/ The rate per 100,000 of nonfatal injuries due to MVC among children 14 and younger in 2007 was 145.0 compared to 192.7 for the same time period in 2006. The projected estimate for 2008 is also 145.0 (921 injuries among 635,195 individuals aged 14 and younger). No specific objective is listed in the Healthy People 2010 objective, however, this health status indicator is related to objective 15-17: Reduce non-fatal injuries caused by motor vehicle crashes to 1,000 non-fatal injuries per 100,000 population. (Baseline: 1,270 non-fatal injuries per 100,000 in 1997)

The MSDH houses a position called the Child Death Review Panel (CDRP) Coordinator that serves on a panel that has been tasked by the state legislature with gaining a better understanding of the causes and circumstances of unexplained infant and child deaths with the goal of providing recommendations that lead to their reduction. Motor vehicle crashes is one of the Causes of Death categories described in a report that is submitted annually to the state legislature. In 2008, a law was passed mandating booster seats for children of a certain age and size and in 2009 a law was passed strengthening requirements for obtaining graduated driver's licences. Representatives from organizations such as the MS Department of Human Services, the State Medical Examiner's Office, March of Dimes, University of Mississippi Medical Center, and the Attorney General's office serve on this panel and collaborate on advocacy issues and related legislation.

The Injury and Violence Prevention Program continues to target motor vehicle safety and promote correct child occupant protection. In 2008 alone, 5,968 child restraints were distributed across the state of Mississippi. Expansion of the program has involved collaboration with the Pregnancy High Risk Management program, where one district has been selected to pilot the Safety Seat Incentive program. Through this collaboration, the Injury and Violence Program has certified 15 PHRM staff from that district as Child Passenger Safety Technicians and has provided 150 convertible car seats to use as motivational rewards for patient attendance to clinic appointments. Expected outcomes include specific targeting of a high-risk, low-income population and increased compliance with appointment scheduling. //2010//

Health Status Indicators 04C: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	31,419.0	664.7	665.0	537.5	537.5

Numerator	2544	2723	2962	2343	2343
Denominator	8097	409679	445425	435916	435916
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
Denominator in 2004 was not total population for specified age range. This has been corrected. Through this correction, MS now has a true rate per 100,000, however, this correction caused a discrepancy in data from years 2004 to 2005.

Narrative:
/2010/ The rate per 100,000 of nonfatal injuries due to MVC among youth aged 15-25 years is 537.5 for 2007 compared to 665.0 for 2006. The projected estimate for 2008 is also 537.5. There is not a specific objective for Healthy People 2010 for health status indicator 04C, however, it is related to Healthy People 2010 objective 15-17: Reduce any non-fatal injuries caused by motor vehicle crashes to 1,000 non-fatal injuries per 100,000 population (Baseline: 3,116 non-fatal injuries per 100,000 persons aged 16-20 and 2,496 non-fatal injuries per 100,000 persons aged 21-24 years in 1997).

The MSDH houses a position called the Child Death Review Panel (CDRP) Coordinator that serves on a panel that has been tasked by the state legislature with gaining a better understanding of the causes and circumstances of unexplained infant and child deaths, including children who fall within the 15-24 age range, with the goal of providing recommendations that lead to their reduction. Motor vehicle crashes is one of the Causes of Death categories described in a report that is submitted annually to the state legislature. In 2008, a law was passed mandating booster seats for children of a certain age and size and in 2009 a law was passed strengthening requirements for obtaining graduated driver's licences. Representatives from organizations such as the MS Department of Human Services, the State Medical Examiner's Office, March of Dimes, University of Mississippi Medical Center, and the Attorney General's office serve on this panel and collaborate on advocacy issues and related legislation. //2010//

Health Status Indicators 05A: *The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	49.9	61.9	65.8	65.1	64.5
Numerator	5919	6540	7536	7071	7007
Denominator	118728	105697	114460	108589	108589
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a					

3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2007
According to HIV/AIDS program staff, an increase in screening is the justification for rise in Chlamydia cases for this age group. Increased screening oftentimes causes a rise in the number of cases being reported.

Notes - 2006
According to HIV/AIDS program staff, an increase in screening is the justification for rise in Chlamydia cases for this age group. Increased screening oftentimes causes a rise in the number of cases being reported.

Narrative:
/2010/ The rate per 1,000 women aged 15-19 years with a reported case of chlamydia was 65.1 in 2007 compared to 65.8 in 2006. The projected estimate for 2008 is 64.5 per 1,000 women for the estimated population of women 15-19 years of age. Healthy People 2010 objective 25-1: Reduce the proportion of adolescents and young adults with Chlamydia Trachomatitis infections, Objective 21-1a: Reduce the proportion of females aged 15-24 years attending family planning clinics to 3.0 percent (Baseline: 5.0 percent in 1997) Objective 25-1b: Reduce the proportion of females aged 15-24 years attending STD clinics to 3.0 percent (Baseline: 12.0 percent in 1997) //2010//

Health Status Indicators 05B: *The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	16.7	25.7	219.8	18.4	17.7
Numerator	8669	16107	114412	9105	8781
Denominator	520422	627018	520422	496146	496146
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2007
According to HIV/AIDS program staff, an increase in screening is the justification for rise in Chlamydia cases for this age group. Increased screening oftentimes causes a rise in the number of cases being reported.

Notes - 2006
According to HIV/AIDS program staff, an increase in screening is the justification for rise in Chlamydia cases for this age group. Increased screening oftentimes causes a rise in the number of cases being reported.

Narrative:
/2010/ The rate per 1,000 women aged 20-44 years with a reported case of chlamydia for 2007 was 18.4 compared to 219.8 for 2006. According to HIV/AIDS program staff, the

difference from 2006 to 2007 was due to number of individuals screened. The projected estimation for 2008 is 17.7 per 1,000 women aged 20-44. No specific objective for Healthy People 2010 is formalized for health status indicator 05B for this age group and gender. Related to this health status indicator is objective 15-18: Increase the proportion of primary care providers who treat patients with sexually transmitted diseases and who manage cases according to recognized standards. The related objectives are Objective 21-1a: Reduce the proportion of females aged 15-24 years attending family planning clinics to 3.0 percent (Baseline: 5.0 percent in 1997) Objective 25-1b: Reduce the proportion of females aged 15-24 years attending STD clinics to 3.0 percent (Baseline: 12.0 percent in 1997) //2010// //2010//

Health Status Indicators 06A: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

HSI #06A - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	45433	23092	20997	246	334	14	750	0
Children 1 through 4	173849	91786	76856	1027	1453	39	2688	0
Children 5 through 9	207138	110835	89880	1160	1883	61	3319	0
Children 10 through 14	208775	109327	93880	1163	1683	84	2638	0
Children 15 through 19	221505	117353	99187	1297	1525	78	2065	0
Children 20 through 24	214411	117366	92355	1245	1672	96	1677	0
Children 0 through 24	1071111	569759	473155	6138	8550	372	13137	0

Notes - 2010

Narrative:
/2010/ The demographic changes in the State of Mississippi for infants and children 0-24 years of age indicates increases in infants 0 to1, children 1-4, children 5-9, and overall total for 0-24 but decreases in children 10-14 when compared to the same age groupings for 2006. Of the 13,137 infants and children reporting more than one race, there is an increase from the previous year of 14.5%. The source of these data is the US Census and any changes in the demographic makeup of the State of Mississippi are based on their estimation models using 2000 census and projected migration patterns models. No specific Health People 2010 objective is formalized for health status indicator 06A. //2010//

Health Status Indicators 06B: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)*

HSI #06B - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	44178	1255	0
Children 1 through 4	168573	5276	0
Children 5 through 9	201051	6087	0
Children 10 through 14	203542	5233	0
Children 15 through 19	216947	4558	0
Children 20 through 24	209618	4793	0
Children 0 through 24	1043909	27202	0

Notes - 2010

Narrative:
/2010/ Total Hispanic or Latino totals changed by +22.9% when comparing 2006 and 2007 data. The source of this data is the US Census and any changes in the demographic makeup of the State of Mississippi are based on their estimation models using 2000 census and projected migration patterns models. No specific Health People 2010 objective is formalized for health status indicator 06A. //2010//

Health Status Indicators 07A: *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

HSI #07A - Demographics (Total live births)

CATEGORY Total live births	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Women < 15	155	37	115	2	1	0	0	0
Women 15 through 17	2655	999	1630	21	5	0	0	0
Women 18 through 19	5144	2274	2798	55	13	3	0	1
Women 20 through 34	35010	19255	15168	218	294	69	0	6
Women 35 or older	3489	2218	1167	14	73	16	0	1
Women of all ages	46453	24783	20878	310	386	88	0	8

Notes - 2010
Births in Mississippi for 2007 was 46,455 (total live births) Form 21 does not allow for any unknown age groups. Two births were born to mothers with unknown age, therefore the total of 46,453 does not match with the 2007 Annual Vital Statistics reported births of 46,455

Narrative:
/2010/ The number of live births for women of all ages changed little when comparing 2006/2007; the number of births were 46,042 and 46,453 respectively. The number of live births for women < 15 decreased from 173 to 155 for the years 2006 and 2007; this represents a decrease of 11.6% in this category. No specific Healthy People 2010 objective

is formalized for health status indicator 07A //2010//

Health Status Indicators 07B: *Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)*

HSI #07B - Demographics (Total live births)

CATEGORY Total live births	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Women < 15	148	4	3
Women 15 through 17	2531	72	52
Women 18 through 19	4876	167	101
Women 20 through 34	31816	1255	1939
Women 35 or older	3014	119	356
Women of all ages	42385	1617	2451

Notes - 2010

Narrative:
/2010/ The number of live births for women of all ages changed little when comparing 2006/2007; the number of births were 46,042 and 46,453 respectively. The number of live births for women not Hispanic or Latino < 15 decreased from 168 to 148 for the years 2006 and 2007; this represents a decrease of 11.9% in this category. No specific Healthy People 2010 objective is formalized for health status indicator 07B. //2010//

Health Status Indicators 08A: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

HSI #08A - Demographics (Total deaths)

CATEGORY Total deaths	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	469	164	293	9	3	0	0	0
Children 1 through 4	91	42	48	1	0	0	0	0
Children 5 through 9	48	23	24	0	1	0	0	0
Children 10 through 14	63	34	28	1	0	0	0	0
Children 15 through 19	216	122	91	2	1	0	0	0
Children 20 through 24	315	165	147	0	1	0	0	2
Children 0 through 24	1202	550	631	13	6	0	0	2

Notes - 2010

Narrative:
/2010/ The number of deaths of infants and children aged 0 through 24 years decreased in the category 0 to 1 from 2006 to 2007 from 483 deaths to 469 deaths. The remaining categories indicated increased in number of deaths in 2007 when compared to 2006 for the same age categories. No specific Healthy People 2010 objective is formalized for health status indicator 08A. //2010//

Health Status Indicators 08B: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)*

HSI #08B - Demographics (Total deaths)

CATEGORY Total deaths	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	391	5	73
Children 1 through 4	72	3	16
Children 5 through 9	38	2	8
Children 10 through 14	52	1	10
Children 15 through 19	193	2	21
Children 20 through 24	279	15	21
Children 0 through 24	1025	28	149

Notes - 2010

Narrative:
/2010/ During 2007 the number of deaths of infants and children aged 0-24 for non Hispanic or Latino increased to 1,025 from the reported number of deaths (1,007) in 2006. The number of Hispanic or Latino for the subgroups 0 to 1 changed from 12 (2006) to 5 (2007). No specific Healthy People 2010 objective is formalized for health status indicator 08B. //2010//

Health Status Indicators 09A: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

HSI #09A - Demographics (Miscellaneous Data)

CATEGORY Misc Data BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**	**Specific Reporting Year**
All children 0 through 19	NaN	452393	380800	4893	6878	276	11460	0	2007
Percent in household headed by single parent	44.0	22.0	71.0	0.0	0.0	0.0	0.0	0.0	2007

Percent in TANF (Grant) families	8.9	5.3	10.2	1.8	4.5	7.8	0.6	8.9	2008
Number enrolled in Medicaid	NaN	126640	235337	1786	1880	184	0	37762	2008
Number enrolled in SCHIP	NaN	27723	31901	283	460	53	0	3	2008
Number living in foster home care	NaN	2634	2848	23	4	3	0	45	2007
Number enrolled in food stamp program	NaN	59496	185424	984	332	100	1374	2307	2008
Number enrolled in WIC	NaN	42179	72478	253	398	250	445	5280	2008
Rate (per 100,000) of juvenile crime arrests	3757.0	1180.0	2562.0	3.0	11.0	0.0	0.0	0.0	2006
Percentage of high school drop-outs (grade 9 through 12)	15.9	13.5	18.2	22.0	10.3	0.0	0.0	0.0	2007

Notes - 2010

Narrative:
/2010/ Data utilized in Health Status Indicator 09A comes from several national and state data sources. The following areas were updated from the data from the previous application because of newer data being available. Those areas were TANF, Medicaid, SCHIP, food stamp program, and WIC. No specific Healthy People 2010 objective is formalized for health status indicator 09A. //2010//

Health Status Indicators 09B: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity. (Demographics)*

HSI #09B - Demographics (Miscellaneous Data)

CATEGORY Miscellaneous Data BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**	**Specific Reporting Year**
All children 0 through 19	834291	22409	0	2007
Percent in household headed by single parent	99.1	0.1	0.0	2007
Percent in TANF (Grant) families	0.0	0.0	0.0	2008
Number enrolled in Medicaid	365834	10504	27251	2008
Number enrolled in SCHIP	60420	1200	3	2008
Number living in foster home care	5231	99	117	2007
Number enrolled in food stamp program	0	0	0	2008

Number enrolled in WIC	116003	5280	0	2008
Rate (per 100,000) of juvenile crime arrests	3746.0	11.0	0.0	2007
Percentage of high school drop-outs (grade 9 through 12)	80.6	19.4	0.0	2008

Notes - 2010
Data was not available from source Mississippi Department of Human Services for ethniciites. Analyst stated data not availalble for ethnicity variable (TANF).

Agency reporting Food Stamp enrollment states unable to provide ethnicity due to changes in programming and would require a special customized program to extract the data, MDHS representative states.

Specific reporting years listed as 2007 represent the most current data available from the reporting source for that indicator.

Narrative:
/2010/ Data utilized in Health Status Indicator 09A comes from several national and state data sources. The following areas were updated from the data from the previous application because of newer data being available. Those areas were TANF, Medicaid, SCHIP, food stamp program, and WIC. No specific Healthy People 2010 objective is formalized for health status indicator 09B. //2010//

Health Status Indicators 10: *Geographic living area for all children aged 0 through 19 years.*

HSI #10 - Demographics (Geographic Living Area)

Geographic Living Area	Total
Living in metropolitan areas	381809
Living in urban areas	380751
Living in rural areas	488018
Living in frontier areas	0
Total - all children 0 through 19	868769

Notes - 2010

Narrative:
/2010/ Mississippi is a predominantly rural state with a majority of its population 0-19 years of age living in rural areas. Many in this population are poor and face unique barriers to care because of a lack of providers, too few providers that accept Medicaid or CHIP, and/or limited means of transportation to health care facilities. Mississippi's population 0-19 years of age that are poor and live in metropolitan and/or urban areas of the state may tend to overuse emergency departments or public health clinics if there is a lack of coordinated health services available to them. While not as large a population as that found in the rural areas of the state, the urban population is significant and potentially strains emergency department and public health clinic resources that are more apt to be found in our urban areas.

While there is little that the state MCH program can do to influence Mississippi's population geography, it can provide resources to develop and implement services that address barriers to access, the frequency with which emergency services are relied upon

for primary care purposes, and critical public health problems such as high rates of infant mortality. An example of this is the development of the DIME and MIME programs that are described in the Agency Capacity section of the MCH block grant application/annual report.

Data for this health status indicator were obtained from the United States Department of Agriculture and the United States Census Bureau. //2010//

Health Status Indicators 11: *Percent of the State population at various levels of the federal poverty level.*

HSI #11 - Demographics (Poverty Levels)

Poverty Levels	Total
Total Population	2918785.0
Percent Below: 50% of poverty	8.8
100% of poverty	20.7
200% of poverty	44.9

Notes - 2010

Narrative:
/2010/ Mississippi is one of the poorest states in the country with high rates of poverty compared to the United States average. Our ability to provide Medicaid and CHIP services are challenged both by the large proportion of people living in poverty and the low number of providers that are willing to participate in and provide services to the Medicaid and CHIP population. Efforts to increase reimbursement rates in these programs are met with resistance because of competing priorities on how budget dollars are spent and budget restraints during difficult economic conditions.

Another challenge for Mississippi is the requirement for in person recertification (face-to-face) for families seeking Medicaid/CHIP benefits for their children. Mississippi is the only remaining state to require face-to-face recertification since New York's decision to remove its own requirement. It is estimated that 60,000 children have been cut from the Medicaid/CHIP roles as a result of the rule.

Data for this health status indicator were obtained from the Mississippi Kids Count Data Book, the Annie E. Casey Foundation, and the United States Census Bureau. //2010//

Health Status Indicators 12: *Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.*

HSI #12 - Demographics (Poverty Levels)

Poverty Levels	Total
Children 0 through 19 years old	868769.0
Percent Below: 50% of poverty	14.0
100% of poverty	29.4
200% of poverty	54.0

Notes - 2010

Narrative:

/2010/ Challenges that are faced by children 0-19 years of age are similar to those faced by the population in health status indicator #11. Services such as EPSDT and WIC provide critical support but children still face obstacles in accessing needed health care services. With shrinking state budgets and growing demand for Medicaid and CHIP, the MSDH must continue to collaborate with other public and private agencies to pool resources and talent to identify, develop and implement evidence-based interventions in a cost-effective manner that target the population 0-19 years of age. Mississippi will begin its next needs assessment in the fall of 2009 and focus on partnerships and interventions, including current programs, which meet the above criteria in an effort to improve the health of our children.

Data for this health status indicator was obtained from Mississippi Kids Count Data Book, the Annie E. Casey Foundation, the Mississippi Division of Medicaid, and the United States Census Bureau. //2010//

F. Other Program Activities

Program begins new topical Fluoride Varnish Program to Prevent Dental Decay for At-Risk Children in Head Starts Programs

Mississippi's dental practice act is one of the most restrictive in the U.S.; it requires that auxiliary dental workers can only perform preventive dental procedures when under the direct supervision of a licensed dentist. This rule makes it impossible to conduct school-based procedures without having a dentist physically present with the worker. There is one exception to this rule; dental hygienists who work for MSDH are permitted to provide dental screening and education under the general supervision of a licensed dentist. During the 2007 MS Legislative Session, we attempted to expand this permission to allow for the application of fluoride varnish by licensed dental hygienists in school-based settings under general supervision.

Fluoride varnish is a lacquer containing fluoride that is painted on teeth to change bacterial activity associated with dental caries. Most fluoride varnish products contain 5 percent sodium fluoride. Fluoride varnish decreases the acidic environment caused by plaque, is not inactivated by plaque, can reverse early decay and may promote the remineralization of tooth enamel as well as decrease tooth sensitivity. Fluoride varnish sets on contact with teeth in the presence of saliva, which gives it some advantage for use in populations where other topical fluorides might be ingested, such as young children in day care settings and persons with neurodevelopmental and intellectual disabilities.

House Bill 930 and Senate Bill 2595 were introduced in the 2007 MS Legislative Session to amend the State Dental Practice Act to allow licensed dental hygienists to perform preventive procedures through organized community outreach under the general supervision of a licensed dentist. Both bills failed but the MS State Board of Dental Examiners agreed to consider the issue. In June 2007, the State Dental Board amended Board Regulation 13 to allow dental hygienists in the employ of MSDH to apply fluoride varnish as part of any oral hygiene instruction and screening procedure. We have been working with Head Start programs to develop a clinical oral health survey and fluoride varnish initiative for the 2007-2008 school-year.

School Nurse Program

For the 2007-2008 school year, the MS Department of Education (MDE) reports 419 school nurses statewide. 94% of these nurses are Registered Nurses (RN), and 6% are Licensed Practical Nurses (LPN). An LPN must be supervised by an RN to meet Mississippi School Nurse Procedures and Standards of Care guidelines. In addition, there are 2 Nurse Practitioners, and 10 Certified Nurse Assistants.

Overall, the average across the state was 2.7 school nurses per district. The MDE estimates a nurse to student ratio of 1:1174 - a number well above the National School Nurse Association's recommendation of 1:750 for general student population or 1:225 when students with special health care needs are mainstreamed with other students.

/2010/ For the period defined as the 2008-2009 school year, the MDE reports 457 school nurses statewide. Ninety-three percent of these nurses are RNs, and 6% are LPNs. An LPN must be supervised by an RN to meet Mississippi School Nurse Procedures and Standards of Care guidelines. In addition, there are 5 Nurse Practitioners working in our schools, representing 1% of the total number of school nurses. Certified Nurses Assistants (CNA) are not included in the total, but there are 8 working with nurses in the schools across the state.

Overall, the average across the state was 3.0 school nurses per district. The MDE estimates a nurse to student ratio of 1:1092 - a number well above the National School Nurse Association's recommendation of 1:750 for general student population or 1:225 when students with special health care needs are mainstreamed with other students. There are 12 identified school districts within the state with no school nurse staff which include the following counties: Benton, Bolivar, Clarke, Clay, Hinds, Holmes, Quitman, Scott, Sunflower, Wilkinson, & Yazoo.

Osteoporosis Activities

The MSDH participates in Osteoporosis Awareness Month in May of each year by performing various screenings statewide. The MSDH has continued to explore ways to work with schools and organizations to offer osteoporosis awareness and education.

The Osteoporosis screening and awareness program establishes, maintains and promotes an osteoporosis prevention, treatment and education program. Osteoporosis may be attributed to three factors: (1) accelerated bone loss at menopause in women or as men and women age; (2) suboptimal bone growth during childhood and adolescence resulting in failure to reach peak bone mass; and (3) bone loss secondary to disease conditions, eating disorders, or certain medications and medical treatments.

It is critical that patients understand what osteoporosis is and what their responsibility to their own body. Osteoporosis is usually preventable. Females need to take steps to protect the health of their bones while they are still children, and on through their teenage and young adult years. Building strong bones at a young age will lessen the effect of the natural bone loss that begins to occur around age 30. Exercise builds bone and muscle strength, helps prevent bone loss, and improves coordination to prevent falls.

The MSDH's Osteoporosis staff uses the Achilles Express, a bone ultrasonometer, to detect osteoporosis or low bone density. Low bone density is an indicator, or early warning, that osteoporosis exists. The machine measures ultrasound variables of the os calcis to provide a clinical measure called the Stiffness Index. The Stiffness Index indicates the risk of osteoporotic fracture in postmenopausal women comparable to bone mineral density (BMD) as measured by x-ray absorptiometry at the spine or hip. This procedure is painless and noninvasive. Early diagnosis is important so that treatment can begin and prevent the condition from getting worse.
The Office of Women's Health at MSDH, with 27 partners, screened 1,332 individuals at 37 sites in 2008. Of this total the following had T Scores/stiffness was found, 883 were normal, 382 were osteopenic, and 67 were osteoporotic.

Follow-up questionnaires were sent to clients six to nine months after their at-risk or high-risk screen was completed. Some screening partners provide their own follow-up to

clients screened at their site. Of the letters mailed through December 2008, many of the clients responded with positive comments on the returned questionnaires.

Child Death Review (CDR) Panel Update (from B. Agency Capacity)

The MSDH houses a position called the Child Death Review Panel (CDRP) Coordinator that serves on a panel that has been tasked by the state legislature with gaining a better understanding of the causes and circumstances of unexplained infant and child deaths with the goal of providing recommendations that lead to their reduction. In 2008, a law was passed mandating booster seats for children of a certain age and size and in 2009 a law was passed strengthening requirements for obtaining graduated driver's licenses. Representatives from organizations such as the MS Department of Human Services, the State Medical Examiner's Office, March of Dimes, University Medical Center, and the Attorney General's office serve on this panel and collaborate on advocacy issues and related legislation.

The CDR Panel will be evaluated during the next needs assessment and considered for inclusion in the list of state priorities going forward.

Early Hearing Detection and Intervention in Mississippi (EHDI-M)

EHDI-M, described in B. Agency Capacity, received a HRSA grant to improve follow-up and identify medical homes. Progress has been made in decreasing the number of infants lost to follow up. Enhanced efforts have also been made in early and appropriate referrals to other child health programs such as Early Intervention and High Risk Management.

The state has applied for a CDC grant to improve data capacity through tracking, surveillance, and integration.

SIDS Program

The SIDS program continues with its follow-up, outreach and education activities. In 2007, 58 infants died from SIDS compared to 68 infants in 2006 and 91 in 2005 (see B. Agency Capacity). The program partnered with the Asthma Program, Lead Poisoning Prevention Program, and the MS State University Extension Service to provide training on risk reduction to childcare providers and staff.

MCH Toll-Free Hotline
The Mississippi MCH hotline is available on the MSDH website under the Information Desk link found on the home page. In FY 08, the hotline received 1,150 calls in nine months with three months of call logs missing. //2010//

G. Technical Assistance

The MSDH is not requesting any technical assistance during this particular grant period. However, many MCH programs seek technical assistance from other sources and other state programs as needed. For example, simply by attending different professional conferences, such as YRBSS training, MSDH staff gains valuable technical skills and are exposed to technical assistance in various MCH situations specific to their programs.

V. Budget Narrative

A. Expenditures

The three components and the anticipated expenditure amounts are described below:

Component A, Services for Pregnant Women and Infants, is budgeted as follows for FY 2009: $3,161,223 for federal funds (30 percent of the total federal award), $2,702,753 for non-federal funds (34 percent of total non-federal funds).

Component B, Services for Child and Adolescent Health, is budgeted as follows for FY 2009: $3,161,223 for federal funds (30 percent of the total federal award), $2,623,260 for non-federal funds (33 percent of total non-federal funds).

Component C, Services for Children with Special Health Care Needs, is budgeted as follows for FY 2009: $3,161,223 for federal funds (30 percent of the total federal award), $2,623,260 for total non-federal funds (33 percent of total non-federal funds).

Administrative Costs are budgeted at $1,053,740 which is 10 percent of the total federal grant award. This amount will not exceed the allowable 10 percent of the total MCH Block Grant as mandated in OBRA 1989.

Personnel are employed to develop and implement standards of care as well as to directly provide services to clients. Typically, classes of employees include physicians, social workers, nurses, nurse practitioners, nutritionists, health aides and clerical staff. Employees are required to meet the standards for practice as specified by his or her professional organization.

Travel is reimbursed for official duty at the state authorized rate of $0.505 per mile. Government contract rates for lodging and per diem ceilings for subsistence are also utilized.

Equipment including minor medical and office, may be purchased in order to administer the program. The equipment items are minor parts of the budget. State regulations governing purchase of equipment are strictly followed.

Supplies include the necessary clinical and office materials to operate the programs and to deliver patient care. Supplies are purchased centrally and according to purchasing policy of state government.

Contractual reflects funds budgeted to purchase services from outside providers. Examples would be for high risk medical care for women and CSHCN.

Construction: none

Other includes telephone, copying and postage used on behalf of the block grant program.

/2010/ The MSDH will expend funds for the four tiers of services (infrastructure building, population-based, enabling, and direct health care). Services will target the three MCH population groups of pregnant women, mothers, and infants; children and adolescents; and children with special health care needs, with an emphasis on those in families living at or below 185 percent of the federal poverty level. This includes services to be provided or coordinated for individuals by category of individual served and source of payment or for budgeting/accounting/auditing for each capacity building activity described in the Annual Plan (e.g., public health leadership and education, assessment, policy development, planning, technical assistance, standard setting, quality assurance, and the like).

Personnel are employed to develop and implement standards of care as well as to directly

provide services to clients. Classes of employees include physicians, social workers, nurses, nurse practitioners, nutritionists, health aides and clerical staff. Employees are required to meet the standards for practice as specified by his or her professional organization.

Travel is reimbursed for official duty at the state authorized rate of $0.55 per mile effective January 1, 2009 (the previous authorized rate was $0.505). Government contract rates for lodging and per diem ceilings for subsistence are also utilized.

Minor medical and office equipment, not major medical equipment, may be purchased in order to administer the program. The equipment items are small parts of the budget. State regulations governing purchase of equipment are strictly followed.

Supplies include the necessary clinical and office materials to operate the programs and to deliver patient care. Supplies are purchased centrally and according to purchasing policy of state government.

Contractual reflects funds budgeted to purchase services from outside providers. Examples would be for high risk medical care for women and CSHCN.

Construction: none

Other includes telephone, copying and postage used on behalf of the block grant program. //2010//

B. Budget

The budget for Mississippi's MCH Block Grant application was developed by Health Services in cooperation with the Office of Health Administration, Bureau of Finance and Accounts. The total program for FY 2009 is $18,486,681 of which $10,537,408 (57 percent) is Title V and $7,949,273 (43 percent) is match provided in-kind by the applicant. Sources of match funds are state funds, Medicaid earnings (as allowed by the MCH Bureau), and other Third Party earnings. Other federal funds available to support the MCH objectives are listed on Form 4.

The MSDH will expend funds for the four types of services (Core Public Health/Infrastructure, Population Based Individual Services, Enabling and Non-Health Support, and Direct Health Care Services). Services will target the three categories including pregnant women and infants, children and adolescents, and Children with Special Health Care Needs, specifically those in families living at or below 185 percent of the federal poverty level. This includes services to be provided or coordinated for individuals, by category of individual served and source of payment or for budgeting/accounting/auditing for each capacity building activity described in the Annual Plan (e.g., public health leadership and education, assessment, policy development, planning, technical assistance, standard setting, quality assurance, and the like).

Maintenance of Effort: As noted on Form 10, the State Profile, the level of state funds provided for match for FY 2009 is greater than the State's "maintenance of effort" level, i.e., the total amount of State funds expended for maternal and child health program in FY 1989.

Matching funds for the MCH Block Grant are identified by listing all direct program costs which have been paid from non-federal sources. These expenses include travel, medicine, medical services, clinical, and lab supplies. Funds used to match Medicaid or other grants are deducted. All salary and non-salary charges for the Children with Special Health Care Needs program are identified by budget. The agency time study provides a report of the value of staff time paid from state or county funds. Time coded to Family Health, Family Planning, Maternity, Perinatal High Risk Management and other Maternal and Child Health efforts is used to match the Perinatal Services category. Time coded to Child Health, Dental Health and School Nurse is used to match

the Children and Adolescent category.

/2010/ The budget for Mississippi's MCH Block Grant application was developed by MSDH Health Services in cooperation with the Office of Health Administration, Bureau of Finance and Accounts. The total program for FY 2010 is $18,486,681 of which $10,537,408 (57 percent) is Title V and $7,949,273 (43 percent) is match provided in-kind by the applicant. Sources of match funds are state funds, Medicaid earnings (as allowed by the MCH Bureau), and other Third Party earnings. Other federal funds available to support the MCH objectives are listed on Form 4.

Services for pregnant women and infants are budgeted as follows for FY 2010: $3,161,223 for federal funds (30 percent of the total federal award), $2,702,753 for non-federal funds (34 percent of total non-federal funds).

Services for the Child and Adolescent Health program are budgeted as follows for FY 2010: $3,161,223 for federal funds (30 percent of the total federal award), $2,623,260 for non-federal funds (33 percent of total non-federal funds).

Services for children with special health care needs are budgeted as follows for FY 2010: $3,161,223 for federal funds (30 percent of the total federal award), $2,623,260 for total non-federal funds (33 percent of total non-federal funds).

Administrative costs are budgeted at $1,053,740 which is 10 percent of the total federal grant award. This amount does not exceed the allowable 10 percent of the total MCH Block Grant as mandated in OBRA 1989.

Maintenance of Effort: As noted on Form 10, the State Profile, the level of state funds provided for match for FY 2010 is greater than the State's "maintenance of effort" level, i.e., the total amount of State funds expended for maternal and child health program in FY 1989.

Matching funds for the MCH Block Grant are identified by listing all direct program costs which have been paid from non-federal sources. These expenses include travel, medicine, medical services, clinical, and lab supplies. Funds used to match Medicaid or other grants are deducted.

All salary and non-salary charges for the Children with Special Health Care Needs program are identified by budget. The agency time study provides a report of the value of staff time paid from state or county funds. Time coded to Family Health, Family Planning, Maternity, Perinatal High Risk Management and other Maternal and Child Health efforts is used to match the pregnant women, mothers, and infants group. Time coded to Child Health, Oral Health, and School Nurse is used to match the children and adolescent group. //2010//

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.